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LOYOLA UNIVERSITY CHICAGO

UNCOVERING MEDICAL AND MENTAL HEALTH
PROFESSIONALS' DECISION-MAKING
IN THE TREATMENT OF TRANS-VARIANT PATIENTS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIOLOGY

BY

JODIE M. DEWEY

CHICAGO, IL

AUGUST, 2010

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For My Two Guys

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
ABSTRACT	viii
CHAPTER ONE: INTRODUCTION	1
Definition of Terms	1
My Research: Filling Gaps in the Field	5
Dissertation Chapters	6
CHAPTER TWO: LITERATURE REVIEW	8
Historical Development of Trans-Variant Social and Medical Identities	12
Current Medical and Mental Health Documents	28
Standards of Care (SOC)	29
The Diagnostic Statistical Manual (DSM-IV-TR)	33
International Classification of Diseases (ICD-10)	35
CHAPTER THREE: METHODS	37
Data Collection	40
Challenges	41
Confidentiality	42
Interaction of Trans-patients, Medical and Mental Health Providers	44
Conclusion	46
CHAPTER FOUR: FORMAL AND INFORMAL KNOWLEDGE	47
Formal Training	47
Informal Knowledge	52
Finding Resources	52
Interactions	55
Interactions with Trans-Patients	55
Interaction with Other Professionals	60
Trial and Error	66
Conclusion	70
CHAPTER FIVE: PROFESSIONALS' UNDERSTANDING OF OFFICIAL DOCUMENTS USED IN THE TREATMENT OF OF TRANS-PEOPLE	71
ICD-10	72
DSM-IV-TR	72
History	72
Purpose of DSM-IV-TR in Identifying and Treating Trans-People	73
Current DSM Debates	75

SOC	76
History	76
Purpose of SOC in Treating Trans-People	76
Current SOC debates	77
Professionals' Use of the DSM-IV-TR and SOC	80
Identifying 'Real' Transsexuals	81
Grappling with DSM Diagnoses and Language	90
DSM Needs to be Empirically Grounded	96
SOC Provides Credibility and Protection	98
Re-Working SOC and DSM Guidelines	105
DSM and Insurance Companies	105
SOC	113
Conclusion	116
 CHAPTER SIX: TYPES OF PATIENTS	 118
Difficult Patients	118
Patient Time Demands	119
Patient Unrealistic Expectations	123
Unrealistic Surgical Expectations	124
Unrealistic Social Expectations	126
Patient Co-Morbidity	128
Responses to Difficult Patients	133
Rewarding Patients	136
Making Professionals Feel Good	136
Making Professionals Work Easier	138
(Un)Successful Patients	140
Engaging in the Process	141
Function	144
Socially Functional	144
Sexually and Physically Functional	146
Conclusion	150
 CHAPTER SEVEN: THE PARADOX	
MAKING DECISIONS IN LIGHT OF OFFICIAL UNDERSTANDING AND	
IDIOSYNCRATIC USES OF KNOWLEDGE	151
Re-Interpreting the Professional Role	152
Addressing the Paradox: Professionally-Guided Patient Decision-Making	156
Ensuring Time and Process	157
Recognizing Co-Morbidity	167
Preparing Patients for Surgery	172
When Treatment is Not an Option	175
Conclusion	180

CHAPTER EIGHT: CONCLUSION	183
Knowledge Paradox	183
Decision-Making Paradox	188
Diagnosing	189
Treatment Path	191
Larger Messages for Gender and Medical Work	193
Doctor-Patient Messages	193
Gendered Messages	195
Research Implications	197
DSM-V	197
SOC (7 th Edition)	200
REFERENCE LIST	206
VITA	211

ABSTRACT

This project is a study of medical and mental health professionals who treat trans-variant patients. Using in-depth interviews, I show how providers describe the process by which they make decisions with patients who desire, through formal means, to hormonally and/or surgically transition from one gender to the other. This work uncovers the ways professionals make decisions in the absence or limitation of formal knowledge while simultaneously attempting to ground their work in this same knowledge to obtain respect and legitimacy. Professionals must also acknowledge that they relinquish some power to patients to make decisions which involve high risk for them. Providers attempt to balance these demands all while attempting to be viewed by their trans-patients as ‘good’ doctors and therapists and not gatekeepers.

CHAPTER ONE

INTRODUCTION

In an earlier project, I interviewed 23 trans-identified individuals about their biggest concern related to discrimination and harassment (Dewey 2008).

Overwhelmingly, respondents stated that navigating medical and mental health institutions as one of their most profound concerns. From sensing evaporation of professionals' warm bedside manner after discovering their trans-status to believing that professional's blatantly disregarded their medical and therapeutic needs, many trans-people experienced various forms of mistreatment. These findings were the impetus for my interest in studying medical and mental health professionals' perceptions of treating the trans-identified patient.

Definition of Terms

"Trans-identified individuals" are people who have cross-gendered identification. They permanently live, or occasionally present in the gender opposite to the one they were assigned at birth. Some may also choose to present or live *between* the dichotomy of male and female, as neither always, or fully, one or the other. Trans-identified individuals, a more recent term, stems from the word 'Trans' which was first used by a parliamentary discussion group in London (1998) in hopes of being inclusive when urging for equality legislation (Whittle 2006). While many people identify as Trans, there are various ways that one may choose to transition to the gender they believe

themselves to be. Some may choose to physically, surgically, and/or hormonally adapt their bodies to their gender identity while others cannot or choose not to transition in these ways. Some may formally, through medical and psychiatric systems, or informally, such as illegal means, seek out ways to physically and/or medically transition from one gender to the other. Genetic males, who wish to transition to female, may choose to take hormones in order to physically alter their body by using estrogen to feminize the body; genetic females may take testosterone to masculinize the body. Some trans-identified people decide to surgically transition. Examples of surgical transition may include mastectomy, penectomy, orchiectomy, hysterectomy, breast augmentation, and gender confirmation surgery (CGS). There are many reasons why trans-people may decide to obtain these interventions and many reasons why they may not, such as cost, health problems, or disinterest in transitioning in this manner.

In the U.S., those who choose to hormonally and/or medically transition through formal channels, must follow a particular process and involve specific types of professionals to obtain these services. Trans-identified individuals, who want to physically and medically transition from one gender to the other, must seek assistance from both medical and mental health professionals. This requirement is outlined in two main documents used by professionals: The Diagnostic Statistical Manual (DSM-IV-TR) and the Standards of Care (SOC) which I will describe in more detail in upcoming chapters. Medical professionals who provide transitioning-related services include plastic surgeons, endocrinologists, family physicians, and urologists. Medical

professionals will not perform these services until they receive verification, usually in the form of a letter, from at least one psychologist or psychiatrist that the patient has been diagnosed as having gender identity disorder (GID); however, surgeons performing gender confirmation surgery (GCS) require two letters of GID confirmation, at least one from a PhD-level therapist. Mental health providers include psychologists, licensed social workers, sex therapists, and psychiatrists. The letter is a requirement outlined in the SOC which clarifies that the letter must mention a DSM diagnosis of Gender Identity Disorder (GID) in order to access medical interventions. Therefore, the letter actually connects these documents together; each giving the other legitimacy. If patients want legally prescribed hormones, they must then seek out a family physician or endocrinologist who is willing to prescribe to trans-people. If they desire surgeries, they must find a plastic surgeon willing and able to perform the surgery they want. Therefore, this project is about a very specific group of medical and mental health professionals: those who medically and/or therapeutically assist people who want to be officially diagnosed with having GID in order to obtain medical interventions to specifically assist with their physical transformation from one gender to the other. Although many trans-people may transition in various ways, this project is only about those who choose to physically transition through formal medical and therapeutic paths.

Other commonly used terms for trans-identified is “transgender”. According to Viviane Namaste, ‘transgender’ “is an umbrella term used to refer to all individuals who live outside of normative sex/gender relations—that is, individuals whose gendered self-presentation (evidenced through dress, mannerisms, and even physiology) does not

correspond to the behaviors habitually associated with the members of their biological sex” (2000:1). Various terms fall under the generic label of transgender including transvestites and cross-dressers, or individuals who dress as the opposite sex for sometimes sexual gratification; and transsexuals, or what I just described as trans-variant or trans-identified individuals who decide to take hormones or undergo transformative surgeries to physically align their bodies to their desired gender (Stryker 2008). Sometimes “intersex” (hermaphrodites), recently referred to as Disorders of Sex Development (DSD), inappropriately gets included with the term transgender; however those with an intersex condition have a genetic irregularity between how their body appears physically and their chromosomal make up (Stryker 2008:9). According to the Intersex Society of North America (ISNA), which has disbanded and replaced by Accord Alliance, intersex is a “general term used for a variety of conditions in which a person is born with a reproduction or sexual anatomy that doesn’t seem to fit the typical definitions of female or male.” Intersexuality is a medical diagnosis; whereas transsexuality, while emerging from both medical and psychological arenas and despite much debate, is still considered a psychological disorder. Although these terms are an easy way to reference people with perhaps similar behaviors and concerns, they also can conflate and mask subjective identities and experiences (for more information on this debate, see Valentine 2008). Many of these terms emerged through the medicalization of trans-people which I will discuss in Chapter Two, and therefore, some find them to be outdated, insulting, and/or pathologizing.

In this dissertation, I use the terms trans, trans-people, trans-individuals, trans-patients, trans-variant, and trans-identified individuals to refer to those who respondents in my study speak about, in the course of their work. For the most part, trans-patients, according to professionals, identify with a gender different from the one assigned to them at birth and seek out formal means to physically/medically alter their gender. However, when citing text, I will use the terms as they are presented in the original work. I will refer to those who provide medical services to trans-people as medical professionals, doctors, physicians, medical service providers, and practitioners. I will utilize the titles mental health professionals, therapists, and mental health providers to speak about those in the mental health field who assist trans-individuals. At times, I may speak about the group more broadly referring to them as professionals or providers; while at other times I may mention respondent's specific occupations, such as 'plastic surgeon'. In the next sections I will more fully expound on the historical medical and social emergence of terms and the conditions in which they developed.

My Research: Filling Gaps in the Field

Social researchers and theorists who have built upon the understanding of trans-people have left many gaps which my dissertation will aim to fill. Topics related to trans-people's lives are abundant; however none specifically use medical and mental health professionals as their unit of analysis. I have not found any research which looks at professional decision-making with trans-patients, from *their* perspective. While there is some literature *about* professionals, especially in *Journal of Transgenderism*, the literature provides therapists and medical doctors with improved ways of surgically and

therapeutically treating trans-patients rather than sociologically exploring the ways they perform their work (e.g. Mizock & Lewis 2008). These articles simply reinforce rather than challenge existing medical and psychiatric documents, failing to reveal how professionals' decision-making affects and is affected by the medical context in which they practice.

This dissertation will offer insight into the relationship between trans-patients, providers, and medical/psychiatric knowledge that will aid in better comprehension of lived experiences of trans-people, the people who provide care to them, and the systems that regulate that care. The conclusion will make suggestions on how to improve professionals' work, professionals' relationship with patients and colleagues, and the overall care of trans-people who navigate the medical therapeutic systems.

Dissertation Chapters

The rest of this dissertation is prepared in a logical way. Chapter Two will introduce two main parts of the literature. This includes the medicalization of trans-bodies and the subsequent 'teasing out' of trans-identity from other similar, yet quite unique identities. Chapter Two will also shed light on sociological literature more specifically in order to frame my data and analyses. Chapter Three will speak to the methods of my study, how I obtained my sample and collected/analyzed the data, as well as the limitations of the study. The remaining chapters show the unfolding of medical/mental health knowledge and decision-making. Chapter Four uncovers professionals' perspectives on formal forms of trans-knowledge, including their views of and how they incorporate the SOC and DSM into their work. In Chapter Four I also

investigate how professionals acquire other knowledge in the absence of formal training. Professionals' perspectives and experiences of working with both difficult and rewarding patients is the basis of Chapter Five. In Chapter Six I show how medical and mental health providers make decisions related to treated trans-patients. Final discussion in chapter seven reviews the main findings of the study and elucidates the importance of this work for medical sociology and trans-patients.

CHAPTER TWO

LITERATURE REVIEW

The belief that sex is natural, gender results from our biology, and science has ‘proven’ these ideas is both widely believed and intensely debated. Using an historical and sociological analysis, feminist scholars, historians, and sociologists, and many others have successfully documented the social construction of sex, gender, and even scientific and medical research and reasoning. Through the work of feminist scholars and sexologists in the 1960s and 1970s such as John Money (1968) and Anke Ehrhardt (1972) sex and gender were introduced as separate categories. Sex is ascribed through our biology, mainly evidenced through anatomy, hormones, and physiology while gender was an achieved status, the outward presentation of an internal conviction interpreted through cultural, social, and psychological means (Fausto-Sterling 2000; West and Zimmerman 1991). In the 1970s feminist scholarship argued extensively that gender was in fact separate from sex and that gender, not sex, determined inequality many women faced in society. In other words, women experienced differential treatment not because they were innately different than men but that much of that difference was socially constructed within various institutions based on the *perceived* difference and abilities of women (Fausto-Sterling 2000; Messerschmidt 2009). In their work, feminist scholars began the arduous task of revealing the importance of studying gender, apart from sex, as that which structures perceived differences between the sexes rather than any real

biological difference. They documented that gender, a social construction, organizes our life, forcing us to realize our sex through the ways others respond to our bodies (Lorber 1994; Mead 1967). Lorber wrote: “Gender is so pervasive that in our society we assume it is bred into our genes” (1994). However, in their attempts to tease and bring light to gender, gender scholars pushed sex aside as that which was not reducible and hence, not an area for sociological analysis. Therefore sex was still seen as clearly identifiable only through medical and scientific means.

While scholars worked to make gender a social institution apart from sex and the biological determinism supported it, they failed to see how decisions about sex are made and the impact it has on one’s gender. In the last 10 years, some feminists have attempted to bring the physical body back under the purview of feminist and sociological discussion. Judith Butler argued that to speak about human sexuality as a natural state which has not already been affected by social meanings is inappropriate and building an objective truth through science from this point is inadequate (1993).

Our sex is complex and not easily resolved by any one test. Fausto-Sterling (2000) argues that sex is defined by many players on the sociological and medical scene. The cultural views medical and scientific researchers hold about sex affects the questions they ask, what they study, and how they analyze their findings. Their results are also based on the views and tools available to them at the time of their work. For Fausto-Sterling, one’s sex is a social decision, although often made within the confines of medical, scientific, and psychological arenas. While we may rely on scientific expertise

to assign sex, or so we assume, it is our cultural beliefs we already possess about gender that define our sex. In fact, many natural scientists were not interested in studying two distinct sexes until it became politically necessary to differentiate the roles and rights associated with each sex (Laqueur 1990). Therefore, medicine and psychiatry is the vehicle by which cultural views about sex and gender are legitimized and each of us is measured against. Even in day to day situations, we make assumptions about people's sex and respond to them as that sex based on information that fits within what we already assume about men and women, especially in the absence of actually seeing each other's genitals. Messerschmidt writes: "Sex is achieved through the application and social acceptance of identificatory characteristics that proclaim one as "male" or as "female" (2009). We believe there to be only two sexes so we search for proof of one's sex by forcing ourselves to see what has been already socially constructed as clearly male or female; "sex" and "gender" become indistinguishable (Kessler & McKenna 1978; Messerschmidt 2009). Therefore, "in order to shift the politics of the body, one must change the politics of science itself" (Fausto-Sterling 2000). I would also add that in order to change science, we need to change our cultural beliefs about sex, gender, and what the role and goal of medicine should be.

By classifying and organizing bodies and their sexual functions into a body of knowledge, known as sexology, we find the perfect place to begin analyzing the impact science and medicine has had on our cultural perspectives. Although Foucault (1990) argues that we are not created through the field of sexology, we none the less begin to comprehend ourselves in ways constructed by the discipline. Through scientific and

medical attention to such matters, our sexual views and behaviors become regulated, controlled, and given new meanings. Through the developments of the field, new ‘truths’ are formed which mold our cultural beliefs and values about what is normal/abnormal and ultimately provides ‘proof’ that sex, gender, and heterosexuality is ‘natural’, obscuring our ability to see its construction (Fausto-Sterling 2000).

Cultural, political, and religious views support a dichotomous gender, sex, and sexuality-based system and then become embodied or incorporated into our physiological being. We are committed to dualisms of sex, gender, and sexuality which affect how we comprehend, study, and respond to those who fall between these opposite ends (Fausto-Sterling 2000). Those who defy these binaries, rather than challenge our beliefs about these structures, come under the power and control of those who can ‘normalize’ them out of existence (Foucault 1990). While homosexuals and trans-people can be dismissed as mentally ill or going against nature by choosing a lifestyle, intersexuals on the other hand directly threaten the sex dichotomy. Science was to be used to discover new truths about the body, ensuring that no one felt outside the categories of fully male or female (Foucault 1980). This is best displayed in the medical field’s treatment of intersexuals. The medical community has responded by surgically altering intersex people to ‘fit’ within the two-tiered system acceptable to community members, either being fully male or female. Therefore, their non-existence works to solidify the naturalness of sex just as our social response to gender makes difference seem innate as well (Fausto-Sterling 2000; Namaste 2000).

According to Foucault (1980), medical professionals in the 20th century established that everybody was either one sex or the other and therefore responded to hermaphrodites not as a mixture of two sexes as previously thought but of as only one true sex beneath physical ambiguity. How knowledge about sex, gender, and bodies is organized within medicine and psychiatry, reflect larger societal views, and reproduce itself through the regulation of bodies. Trans-variant individuals' bodies and identities are also studied and understood through medical, scientific, and psychiatric lenses. Understanding how this process, over time, has developed is crucial to comprehending the proliferation of medical/psychiatric knowledge and how it impacts trans-patients. This project will shed light professionals' view of gender and the various ways they cast it during the medical encounter.

Historical Development of Trans-Variant Social and Medical Identities

Although many anthropological studies discuss people thought to be precursors of those we understand today as trans-people, transgender, or transsexual, I only intend to show the historical development which have led up to current western understanding of those diagnosed with GID. Westernized trans-history involves both a social and medical/psychological dimension which, over time, has separated and solidified identities. Through medicalization, transsexuality, a relatively new identity, has evolved as a distinct category; therefore, who we would consider today as transsexual, historically would have been labeled as gender inverters, homosexuals, transvestites, cross-dressers, or sado-masochists. Moreover, their unconventional behavior would have been understood as situational, rather than reflective of one's core identity. For example, before

transsexuality was recognized as a separate, viable identity, people such as Billie Tipton and Brandon Teena were understood as cross-dressing to achieve a benefit normally granted to the opposite sex. In Teena's case, the media portrayed 'her' as dressing male to 'trick' women into having a romantic relationship with her. While in Tipton's case, historians presented her cross-dressing as her desire to publicly play jazz music at a time that only men were allowed to perform. Therefore, how Trans have been understood and written erases their identity by explaining cross dressing as nothing more than situational (beng hui 1999; Boyd 1997; Garber 1992). To provide an adequate history of trans-people, it is important to investigate the emergence of particular identities as they were regulated socially and medically, linking medical/psychiatric developments with the emergence of a social, visible, trans-identity. Thus a chronological history uncovers the connection between how professional and non-professional, trans and non-trans' input has brought us to how we currently comprehend and treat trans-identified individuals.

Individuals with GID were not historically recognized as a separate group with different needs. Over the past 150 years, trans-individuals have been given a distinct place within the medical and social terrain. Physicians, sexologists, endocrinologists, and trans-identified activists, to name a few, have attempted to tease out the definition, social, and medical treatment of transsexuals as separate from intersex (hermaphrodites), transvestites, homosexuals, and those who engage in fetishistic behavior. In this section, I will cover these key arguments and how they have added to our current knowledge about transsexuals.

Although cross-dressing has always existed historically, it was not officially regulated in the U.S. until the 1850s when many cities started to enact laws prohibiting dressing in the attire of the opposite sex. Despite official regulation, other social changes provided new freedoms for some. Industrialization and urbanization allowed many individuals, especially men, the opportunity to live outside the confines of their tight-knit communities and families. Additionally, more people began to socialize outside the home and the family, especially with the advancements of movies and sound recordings. Improvements in electricity provided lighting to streets and homes making it possible for people to mingle for longer hours well into the night (Stryker 2008:33). In this environment, members of gay and trans communities, who often shared space and used the terms synonymously, began to flourish.

Earlier written work reveals the confusion and conflation between sexual orientation and gender, gay and transgender. Many understood homosexuality to be a form of gender inversion. In other words, a man who was sexually attracted to other males must be like a woman since the ‘natural’ attraction must always be between opposite sexes. In 1864 Karl Heinrich Ulrichs anonymously wrote a series of booklets in which he described his biological theory about what he termed “urnings”, or men who love other men. German-born Ulrich a lawyer, writer, and self-described urning, explained that urnings were female souls enclosed within a male body and that sexual choice was an indication of gender inversion (Valentine 2008). In 1869, Karl Maria Kertbeny, a German-born citizen of Hungary, journalist, and later a human rights activist, first used the term homosexual to describe same-sex affection but excluded the cross-

gender piece. Both Ulrich and Kertbeny felt such feelings were inborn, therefore were proper medical cases and should not be made illegal (Stryker 2008:37; Valentine 2008:41). Their views laid the foundation for the medical treatment of homosexuality while others during this time believed that sodomy was a sign of wickedness. Ulrich eventually sent his booklets to Richard von Krafft-Ebing, a professor of psychiatry at Vienna who was studying sexual impulses. While they saw homosexuality as natural, Kraft-Ebbing saw it as indicative of degeneration (Stryker 2008).

Krafft-Ebing's conceptual framework presented in *Psychopathia Sexualis*, first published in 1877, laid the foundation for current views of transsexuality and its confusion with homosexuality. While studying psychosexual disorders, Krafft-Ebing identified homosexuality as one type of disorder. He believed people who deviated from heterosexual, procreative sex were emotionally and physically diseased. Rather than viewing homosexuality as an erotic attraction between people of the same sex, he concluded that one's desire for the same sex reflected the variance of one's *gender* instead. This included 'eviration' or a profound alteration in one's character where a male's feelings are similar to a woman's. Krafft-Ebing eventually identified two categories of homosexuality: congenital and acquired. Each has transgender aspects although the form he viewed as most pathological or disturbed is what he termed "metamorphosis sexualis paranoica". It is this group that would translate into the current understanding of transsexual: "people who strongly identify themselves as proper members of the 'opposite' sex, and who wish to physically alter the sex-signifying aspects of their bodies" (2006:21). Krafft-Ebing argued that those who believed

themselves to be the opposite sex either had severe psychosis to think their body was transforming or, especially if atrophy of the male genitals were obvious, must be excessively masturbating. While Krafft-Ebing still maintained that homosexuality and what we now know as transsexuality to be from the same mold, his work did begin a demarcation between the two. He also differentiated between those he described as *metamorphosis sexualis paranoica* with hermaphrodites. Through his observations, he found that some people did not have malformation of the genitals and therefore should not be confused with hermaphrodites, or what we now more commonly refer to as intersex. Therefore, his research began the slow differentiation of identities so apparent today (2006).

While many viewed Krafft-Ebing as the expert on sexuality, Magnus Hirschfeld, also contributed to the political history of gender and sexuality. As portrayed by Stryker (2008) Hirschfeld was a German sexologist who founded the Scientific-Humanitarian Committee in 1897, the first organization devoted to social reform for sexual minorities (Stryker 2008:39). In 1923, Hirschfeld coined and defined the term transvestism, a person who dresses in the attire of the opposite sex (Benjamin 1966; Hirschfeld 1991:12). However, he is not the first to *describe* transvestism as Carl von Westphal, a psychiatry professor in Berlin, defined similar behavior as “contrary sexual feeling” and Havelock Ellis referred to this behavior as “eonism”. What Hirschfeld accomplished was to further separate transvestism from homosexuality, bisexuality, heterosexuality, hermaphroditism, and masochism (fetish). Hirschfeld argued that all people, including homosexuals and transsexuals, were sexual intermediaries because they fell on a spectrum between the

polarized points of pure male and pure female. The type of sexual intermediary depended on 1) sexual organs; 2) other physical characteristics; 3) sex drive and 4) emotional characteristics. Therefore, “absolute” men or women are individuals who have the appropriate sexual organs and look and act as one might expect from someone of their assigned sex. However, Hirschfeld indicated that these absolutes were invented extremes and that no one is truly an ‘absolute’ man or woman as each person, at least to some degree, possess origins of the other sex (2006:35).

Sexual variations based on sexual organs, according to Hirschfeld, were hermaphrodites, or those with split formations of the genitalia. Individuals found under the second category, physical characteristics, were women with beards, men without such ‘manly’ hair growth, or men with womanly movements and vice versa. Examples of sexual intermediaries based on sex drive include men who like masculine women or women who like feminine men. This category involves men who engage with women sexually, as a woman or who enjoy aggressive, sadist women. Another example is women who like gentle, youthful men. In the final category are intermediaries whose love choices are men or women who have the opposite gendered emotions. For example, a woman in this category would desire sensitive men or men who like women who possess a manly character. Individuals can, according to Hirschfeld, display various degrees of each (2006:37).

Hirschfeld also was able to decipher between transvestism and masochism. During Hirschfeld’s time, many, such as Havelock Ellis (Benjamin 1966:12) confused transvestism with masochism because dressing in often times constraining feminine attire

was viewed as ‘painful’. Typical feminine attire at that time included tight, painful corsets, high heels, and pierced ears. Any man who desired to engage in such excruciating acts was seen as masochistic, desiring pain and humiliation. However, Hirschfeld uncovered many reasons aside from pain that compelled men to wear feminine attire. Unlike Krafft-Ebing who argued that particular fetishes stem from an incident in childhood, Hirschfeld believed that fetishes resulted from a combination of heterosexuality, sadism, and openness to an act described as a fetish (i.e. corseting). Since Hirschfeld had many examples of non-transvestites who felt the need to dress a particular way in order to write, compose, or publicly speak, he therefore concluded that transvestites desire feelings of comfort rather than pain and that feminine attire may be symbolic of femininity rather than ‘tools of torture’ (2006:33). He concludes that masochistic fetishes could be incidental and not necessarily the main purpose for those who cross-dress (2006:34).

Hirschfeld further clarified the difference between transvestism and “*metamorphosis sexualis paranoica*” bringing us closer to the current term ‘transsexual’. He felt the main difference was that transvestites, regardless of dressing, were fully aware that they were *not* actually the opposite sex. Those who believed they were the opposite sex, he felt, were delusional and, therefore mentally ill. He found that for some, dressing was more than assistance to a creative act but that the clothes could be “conspicuous, intentional indications of an inner striving”. He found individuals’ clothing to be a feminine part to a male psyche; an indication of a bisexual personality, meshing of an unmatched body and soul, or what he called the mental double-sexuality (2006:34). So

while he clearly pushed knowledge in a way that further clarified and separated transvestism from ‘*metamorphosis sexualis paranoica*’, he retained the phenomenon as a sexual rather than gendered element. However, unlike others during his time, he felt that sexuality stems from both body and mind and is at times beyond personal control. While sexuality consists of both male and female substances and is inborn, it could constantly change depending on how it is ‘awakened’. Based on this conclusion, treatment, mainly through the use of psychotherapy, may attempt to understand the drive to cross-dress but should not eradicate the behavior. If the person wishes, they should be allowed to succumb to their desires (2006:37). Hirschfeld’s political and scientific work not only provided the knowledge by which discrete identities could emerge, it also urged for acceptance and support for natural variations of human gender/sexual behaviors.

In 1949 David O. Cauldwell, a sexologist and surgeon for the United States Army who later became a neuro-psychiatrist for the Department of War, lent support for the role of psychiatry in treating trans-patients. He argued that those with what he called “*psychopathia transsexualis*”, a term most related to transsexualism, had a hereditary condition caused by dysfunctional upbringing which resulted into mental immaturity. While many others researchers at this time did not support Cauldwell’s hereditary theory, they did agree that dysfunctional experiences in childhood may be contributing factors to cross-gender behavior (2006:40). Cauldwell contended that those with ‘*psychopathia transsexualis*’ were not maturing in a manner most appropriate for their biological and sexological status which rendered them psychologically inept. This thinking lent support to psychotherapy as the appropriate cure. Cauldwell’s thinking shows how individuals

and particular behavior have become increasingly defined and managed by medicine and psychology.

By agreeing to be studied in the middle of the 20th century, trans-people influenced researchers' work thereby changing medical perceptions about trans-people and eventually improving their medical treatment. Louise Lawrence, a male cross-dresser in the 1940s and 1950s, was able to impact many medical professionals, including Karl Bowman, a researcher on sexuality and gender variants. Karl Bowman was a staff member at the Langley Porter Psychiatric Clinic at the University of California—San Francisco (UCSF) and former American Psychiatric Association president who studied servicemen housed in psychiatric prisons after the military discovered they were homosexual. After World War II, his work was supported by the state of California in hopes of finding the cause and treatment for homosexuality. Lawrence began a system of networking with other transgendered people by placing personal advertisements in magazines and contacting people whose arrest for cross-dressing were printed in the newspapers. She opened her home in San Francisco to trans-people who traveled to the area to access particular treatments and surgeries and connected transgender people to Bowman and other researchers.

Lawrence, and trans-people like her, made an impression on researchers causing them to reconsider their views about homosexual and trans-people and the best ways to treat them. One such person who Lawrence influenced was Alfred Kinsey, most notable for the development of the “Heterosexual/Homosexual Rating Scale”, a 7-point scale which places people on the spectrum between fully heterosexual and fully homosexual

(Valentine 2008). His work pulled medical researchers away from searching for visible signs of homosexuality, such as in the genitals, musculature, skeletal structures, and voices of patients. He accomplished this by proposing that sexual variations were natural (Valentine 2008:41). It was one of Lawrence's friends, who through her own request for sex surgery challenged the boundaries and ethics of medicine that would profoundly affect transgendered peoples' access to medical care. In 1949, Bowman, Kinsey, and California's state attorney general, Edmund G. Brown provided the opinion that any type of genital modification surgery would certainly cause "mayhem" and that the states would bring criminal charges to any surgeon who attempted to perform it. Their opinion forced surgeons such as Elmer Belt, a Los Angeles urologist, to perform surgeries in private. These lasting perspectives kept trans-people from accessing medical procedures but also influenced activists and professionals to advocate for the eventual reversal of this opinion (Stryker 2008:44).

Virginia Prince, a cross-dresser and researcher at UCSF also contributed to the medical and social experiences of trans-people. Prince is thought to have coined the term 'transgenderist' in the 1970s to describe heterosexual males who dressed and lived as women but who did not desire surgical interventions. Prince sought to present herself and others like her as normal, non-sexually deviant people and therefore differentiated between transgenderists and transsexual men and women and cross-dressers (Stryker 2008; Valentine 2008:32). Therefore, while the term 'transgender' today represents all people under the spectrum of cross-gendered identification, it was not originally introduced this way by Prince. Prince eventually organized the first lasting group

dedicated to transvestites called the 'Hose and Heels Club', which today still exists and is now called Society for the Second Self or Tri-Ess. Prince's social group provided a private space, usually a members' home or hotel room where men could safely cross-dress and socialize. In 1952, Prince co-published the first transgender magazine in U.S. history: *Transvestia: The Journal of the American Society for Equality in Dress*. Prince, who staunchly opposed homosexuality and sex reassignment surgery, fought for a clear description between heterosexual men who dress in women's clothing and homosexual's who performed drag, as these identities were often confused at the time. Prince only allowed married heterosexual men into her social organization. She would not allow membership to homosexuals, transgendered, or female-identified people. Prince was also set on separating transvestites from transsexuals, especially when Christine Jorgensen, the first person publicly recognized for undergoing conversion surgery, made headlines in 1952. By clarifying various identities, many feel that Prince deepened the separation between particular communities making a transgender movement unlikely. However, especially after undergoing her own transition to female in 1968, she began to advocate for more rights for all transgendered people (Stryker 2008).

As discussed above, Christine Jorgensen has played a major role in transgender social and medical history. Christine was born George Jorgensen and was an American photographer and ex-GI. Since conversion surgery was not yet available in the United States, Christine went to Denmark where castration surgery was being performed on sex offenders. Jorgensen's notoriety not only brought an immense amount of public attention to transgender people and issues but her public transformation helped differentiate the

various identities. Initially, the media referred to Jorgensen as a ‘hermaphrodite’ or intersex person but then quickly renamed her ‘transvestite’. However, soon ‘transvestite’ was not appropriate, especially after Virginia Prince clarified that ‘transvestites’ were heterosexual males who like only to cross-dress but not change their sex through surgery (Stryker 2008). It was Harry Benjamin who elevated ‘transsexual’ to a separate identity with its own specialized treatment.

Dr. Harry Benjamin, known as the founding father of contemporary western transsexualism urged that transsexuals be recognized as separate from other identities and legitimated through medical, rather than strictly psychological, treatments. Benjamin, trained as a German doctor and endocrinologist, supported the use of hormones and surgery for the treatment of transsexuals. Working with both Hirschfeld and later, Alfred Kinsey, Benjamin became a staunch advocate for those seeking sex changes in the 20th Century. In 1966, Benjamin wrote *The Transsexual Phenomenon*, a text based on his observations with transsexual and transvestite patients. He felt that without the publicity surrounding Jorgensen’s sex change operation in the 1950’s, he would not have been introduced nor become interested in transsexuals and therefore, could not have written the book (Benjamin 1966).

Benjamin was able to muster others in the medical field to conduct research both on their evaluations of surgical procedures and transsexuals’ attitudes more generally. The performance of sex reassignment surgeries today in the U.S. would not be possible without his writings and professional connections. In 1967, stemming from his research, John Hopkins University opened the Gender Identity Clinic in Baltimore, Maryland and

performed the first legal sex reassignment surgery in the United States (Raymond 1999). Prior to this work, transsexuals who sought help were usually treated through psychotherapy, imprisoned, admitted into a mental institution, or committed suicide (Benjamin 1966). Today such surgeries are performed in several hospitals and clinics across the U.S.

Benjamin is also noted for coining the term ‘transsexualism’ in 1952, when he wrote an article about the Jorgensen case. He used this term to speak about male to female transsexuals only. Benjamin explains that he chose not to use other terms being introduced by other researchers for various reasons. For example, many used the term “transexualist” but Benjamin found transsexualism to be a simpler term. Dr. Van Emde Boas of Amsterdam had used “transexists” but Benjamin felt it was too difficult for Americans to pronounce as it was somewhat of a tongue twister. Dr. John Money, sexologist at John Hopkins University, coined “contra-sexism” but Benjamin felt it ignored the transformation aspect for transsexuals. Hamburger, the lead physician in Jorgensen’s operation, used the term genuine “transvestism” or “eonism”. Dr. Daniel C. Brown spoke of transsexualism as a term related to “sex role inversion” meaning that this type of invert desires surgical alteration of his genitals and has the personality of the opposite sex (Benjamin 1966).

Through other researchers’ attempts to identify and clarify various identities, Benjamin was able to further hone his definitions. Benjamin differentiated between transvestism, homosexuality, and transsexualism. He believed, unlike most at this time, that transvestism was not a sexual deviation or a perversion. He argued that cross-

dressing resulted from 'gender discomfort' and provided an emotional relief and enjoyment which did not include conscious sexual stimulation (1966). While Hirschfeld saw transvestites as a disturbed group of people who dressed in the typical apparel of the opposite gender, Benjamin felt cross-dressing resulted from a deep urge of sexual disharmony between one's physical and mental sexuality (2006:45). According to Benjamin, transvestism is playing a role of the opposite sex while transsexualism (Benjamin 1966; Money 1988:88) denotes a strong urge to change one's entire sexual status, including anatomy. The former acts while the latter wants to be the opposite sex. Following Alfred Kinsey, Benjamin also saw transvestism and homosexuality as separate behavioral phenomena. Yet, he did view them as similar in that both are instinctual drives which create a rift in one's sexual unity (1966:47). He argued that transsexuals could have homosexual inclinations, yet many had reduced libidos and a narcissistic preoccupation with transitioning from one gender to the other (Benjamin 1966).

Benjamin believed too that transvestites may be forms of transsexuals, as explained in his Type Classification which included three groups. Group 1 includes individuals that just wish to publicly dress in the attire of the opposite sex and be accepted as that sex while still feeling, living, and working as the sex assigned at birth. In Group 2, a more severe stage of emotional disturbance were individuals who desired physical changes to their bodies that reflected the opposite sex. However, like Group 1, Group 2 still enjoys and derives pleasure from their genitals; hence physical changes for Group 2 might include gynecomastia (breast development) from hormone consumption. In Group 3, defined as fully developed transsexuals, individuals experience the most

extreme level of gender and sex role disorientation and were classified as the most emotionally disturbed because they were disgusted with their bodies and looked forward to the day that they could permanently alter their sex. (Benjamin 1966:18). Benjamin suggest that some had a lower degree of transsexualism which may be unconscious, usually satisfied with cross-dressing. These individuals do not need therapy. A person with a medium degree of transsexualism may desire some physical changes, such as wanting to take hormones for breast development. They may go from having transvestitic desires of dressing to wanting to begin a full transition. Finally, Benjamin recognized those with a high degree of transsexualism which he termed 'true and full-fledged transsexuals'. For these individuals, having a conversion operation as he called it was the only solution. From this, Benjamin developed his 7 point scale, similar to Kinsey's sex orientation scale which explains the spectrum between heterosexuality and homosexuality, in an attempt to reveal the differences between patients with transsexualism and those with transvestism (1966:28).

Like Hirschfeld, Benjamin supported sex-change surgery and other forms of transition for transsexuals, prescribing hormones to patients as early as the 1920s. Other professionals during this time believed that psychotherapy could 'cure' transsexuals. However, Benjamin supported surgery if a 'cure' could not be found through the use of psychotherapy or psychoanalysis (1966:14). Benjamin, like others, was unclear on whether the origin of transsexuality was psychological, genetic, or endocrine (Money 1988:47). However, he argued that explanations must include biological factors.

Benjamin advocated for more medical and legal recognition of transsexuals and eventually found all forms of therapy to be useless in curing transsexualism.

Benjamin's later work places more attention on transsexuals' ability to "pass" and become "normal" members of society once "they have been assisted in their endeavors by an enlightened medical profession" (Ekins 2005:316). This concern for 'normalcy' led Benjamin to recommend surgery for transsexuals. Benjamin was the first to explore sex change surgery for appropriate applicants. However, he felt that while such a surgery might bring immediate gratification, it would not suffice for many transsexuals because it only alters the secondary sex characteristics. But despite this problem, Benjamin recognized that irreversible surgery with the possibility of regret is a better choice than denying surgeries to all. It was through him that transsexuality "became a distinguishable clinical entity—a diagnosis with a treatment program" (Ekins, 2005:309). Benjamin's work has introduced transsexuals into the medical field, legitimized and medicalized trans-people today. However, what has not changed much is the relationship science has to transsexualism. Benjamin claims that:

We have as yet no objective diagnostic methods at our disposal to differentiate between the two [transvestites and transsexuals]. We—often—have to take the statement of an emotionally disturbed individual, whose attitude may change like a mood or who is inclined to tell the doctor what he believes the doctor wants to hear. Furthermore, nature does not abide by rigid systems. The vicissitudes of life and love cause ebbs and flows in the emotions so that fixed boundaries cannot be drawn (1966: 21).

Together, medical researchers and the pioneering efforts of many trans-people created the possibility for trans-identified to have a recognized, social identity. Medical professionals, such as Harry Benjamin, by acknowledging trans-people's cross-gendered

feelings and providing medical treatments, legitimized a social and medical identity. Moreover, the increasing social visibility of trans-people made the proliferation of medical and psychiatric research more likely, and in turn, the more studies that were conducted the more opportunities trans-people had to build a visible social identity and a trans-community. Unlike individuals who made up Prince's FPE organization, most trans-people did not have the privilege, money, or private space to cross-dress and therefore had to physically and symbolically vie for social visibility. Trans-people who chose or had no other option but to present publicly were more likely to be harassed and mistreated by police and community members (Stryker 2000:63).

Current Medical and Mental Health Documents

Benjamin's work continues to impact how trans-people are identified and medically and socially treated. His views eventually led to the Harry Benjamin International Gender Dysphoria Association (HBIGDA), the first professional organization for medical and mental health professionals treating trans-patients. More recently the name changed to the World Professional Association of Transgender Health (WPATH). This organization created the Harry Benjamin Standards of Care (SOC). The SOC are clinical, medical, and psychological guidelines for the management of transsexuals or those diagnosed with GID as specified in the DSM-IV-TR. On the other hand, the DSM-IV and ICD-10 give diagnostic criterias: "[All] three documents attempt to set uniform standards for medicine that interact with legal, medical, social, and state concerns about how medicine is and should be practiced" (Matte, Devor, & Vladicka 2009:43). According to Matte et al (2009), the SOC and the DSM, most used by U.S.

medical and mental health professionals, are based on professional agreement derived from their clinical/medical experiences rather than scientific research. They are also what Matte et al call ‘living’ documents in that they are continually altered, reflecting changes in medicine and societal views (43).

Standards of Care (SOC)

The SOC were first developed in 1977 by a committee of American clinicians and professionals, including one transgender activist while attending the 5th International Gender Dysphoria Symposium. Soon after, this group created the international organization, WPATH, whose members include mostly medical and psychological professionals who treat trans-patients as well as students, researchers, and activists, trans and non-trans alike. During this same meeting, the committee drew the first draft of the SOC (Matte et al, 2009: p.44). Now in its 6th edition, WPATH professionals continually revise and approve versions of the SOC. The SOC were developed to benefit both trans-identified patients and professionals. The SOC professionalizes and provides scientific respectability to medical and mental health providers’ work with trans-patients. By standardizing the treatment of trans-people, it also improves communication and research between clinicians and scientists.

One way of professionalizing the work of those who study and treat trans-people is to develop set definitions. Earlier versions of the SOC deferred to both the ICD and the DSM criteria for diagnosing patients. Some professionals began to realize how they diagnosed and referred to patients in clinical practice was not aligned with the language found in the DSM or ICD. For example, in the DSM-III, the diagnosis for

transsexualism did not include intersex individuals. However, the SOC-III during this same time stated that it followed the DSM-III but then later in the same section of the document it clarified that it did not exclude intersex persons from the diagnosis of transsexualism. WPATH members may have experienced internal inconsistencies in developing versions of the SOC because they were attempting to create clinical guidelines using diagnostic language. Therefore, version 5 of the SOC excluded diagnostic terminology used in the DSM and only retained ICD-10's diagnostic criteria of "gender identity disorders." Many viewed this term as more inclusive and reflective of trans-patients experience than the former "transsexualism." Committee members, however, did not provide an explanation for eliminating DSM criteria from the 5th version of the SOC. They argue that clinical practices were the impetus that led to the exclusion of prior pathologizing DSM terminology used in the SOC and the inclusion of the term gender identity disorder (Matt et al 2009:45).

Other medical and legal terms which provided legitimization for professionals but simultaneously pathologized patients were "disease" and "disorder" (Matte et al: 2009: 46). The SOC focus on disease and disorder justified treatment for trans-people. Some therapists, doctors, and patients feel these terms present patients as sick or in need of correction rather than as a variation of the human experience, as supported in trans-related research and suggested by Benjamin. Additionally, some argue that diagnoses and the SOC must consider the various ways people understand their gender identity and not assume that all trans suffer from identity *disorder* nor should suffering be a prerequisite to being diagnosed with GID. The current version reads that when a patient

with GID has significant suffering because of their gender identity, then they are considered having a mental disorder. This point stems from the DSM-IV and the ICD-9. GID patients may or may not experience mental anguish, depression, or anxiety related to their gender identity, but may experience such suffering due to discrimination, prejudice, and mistreatment by others, not so much because they have gender identity variance (GIV). Therefore, professionals should consider GIV part of human diversity rather than a disease or mental disorder (Winter 2009:34).

Another way the current version of the SOC ignores the various ways trans-individuals identify and present is by indicating that there are ‘two primary populations with GID—biological males and biological females’ (section 1). According to Winter (2009), SOC language pathologizes because it is insensitive to transpeoples’ gender identity variances (GIV). Words such as biological male and female deny individuals self-identification and are not medically correct. Winter argues that biological sex has five components: brain, genital, gonadal, hormonal, and chromosomal. Therefore, a person who identifies as female but was labeled male at birth may be at least partially biologically female based on the four components mentioned. The SOC should incorporate terms which are not only scientifically correct but inclusive of all transpeoples’ identifications, such as ‘female-identifying transperson or transwoman’ (Winter 2009:35).

A final problem with SOC’s language is that it is not inclusive for non-Western trans-identified people. Despite the fact that WPATH is an international organization, it was not until 1990 that the initial introduction of the SOC removed the term *Americans*

and *U.S. citizens* from its first two sentences. Since versions of the SOC were created by Americans and Western Europeans, the language and purpose only reflected and addressed Western trans-related concerns. While version 5 did include a section addressing culturally different manifestations of gender identity disorder, it didn't acknowledge that the application of treatment could differ based on various gender expressions. Those involved in the upcoming 7th edition are considering altering the language and treatment to be more culturally inclusive. Therefore, many argue that language and definitions should consider the needs of the patient and minimize terms which pathologize. Additionally, many believe that by developing more standardized terminology, we will be prepared to conduct quality data collection and improve communication between patients, practitioners, and researchers (Matt et al 2009; 44).

One of the main concerns for the upcoming 7th edition is that its contents are empirically grounded and universal. Many professionals are concerned that what they know about transsexuals and the best way to treat them is not appropriately studied, and therefore not reflected in the SOC. They argue that they want to know the prevalence of people with GID and other identity variances, as well as the epidemiology, or patterns and factors that lead to GID to best revise the next version of the SOC. A weakness in professionals' understanding of trans-identified people is their knowledge mainly comes from personal observations of trans-people. Therefore, until methodologically sound research can be conducted, service providers find that they must use their own discretion rather than base their treatment decisions on the SOC. Perhaps if the contents of the SOC were empirically supported, then professionals would be more likely to adhere to them.

Some also desire a more internationally accepted document to ensure that all practitioners are following the same standards by increasing the opportunity for professionals to be licensed or credentialed in this area (termed as a ‘gender specialist’) Additionally, many professionals suggest that gender specialists should not have to diagnose someone using the DSM-IV-TR just to treat a patient (Matte, Devor, & Vladicka 2009; Winter 2009).

The Diagnostic Statistical Manual (DSM-IV-TR)

Mental health providers refer to the DSM-IV-TR, published in 1994, to identify and diagnose patients with various disorders, including those with gender identity disorder and transvestic fetishism. The DSM provides diagnostic uniformity for professionals to more clearly communicate and conduct research. The first DSM was developed in the early 1900s and it was in 1927 that the American Psychiatric Association supported the DSM as they felt that the International Classification of Diseases (ICD-6) lacked scientific proof (I will more fully explain the ICD in the next section). However, it was not until 1952 that the APA actually published the first DSM for professionals to use in lieu of the ICD-6. Although the APA developed the DSM as an improved tool over the ICD-6, they continued to give input to the World Health Organization (WHO) into future versions of the ICD. This cooperation between the WHO and APA reveals the connection between general medicine and psychiatry (Matte et al, 2009:44). Currently, professionals in various fields are discussing possible changes to the upcoming DSM-V which will be published in 2012.

Currently, two diagnoses found in the DSM-IV-TR pertain to trans-identified individuals: GID and Transvestic Fetishism (TF). HBGDA added transsexualism to the

DSM-III in 1980 (Matte et al 2009:44). In 1994, the DSM changed its diagnosis of Transsexualism to GID. According to the DSM-IV-TR (1994), a patient is diagnosed with GID with proof of intense and persistent feeling of being the opposite sex (also called cross-gender identification) and are continually uncomfortable in their assigned sex. Additionally, to receive a diagnosis of GID, a patient cannot have an intersex condition and must experience extreme distress or impairment in all areas of life. The DSM-IV-TR also provides cues in childhood and adulthood for people experiencing cross-gender identification (DSM 1994:576). For example, the DSM indicates that a young cross-gendered boy will have a 'preoccupation with traditionally feminine activities' and will attempt to dress in feminine attire. Under GID, one can either be diagnosed with Gender Identity Disorder of Childhood, Adolescence, or Adulthood, or those who do not meet these criteria receive the diagnosis of Gender Identity Disorder Not Otherwise Specified (GIDNOS) (SOC 10). The DSM differentiates between GID and those who do not conform to traditional sex roles since in order for patients to be diagnosed with GID they must display all parts of the syndrome (576).

Transvestic Fetishism (FT), another diagnosis used for cross-gendered patients, is listed under paraphilias in the DSM-IV-TR and states that TF's are sexually aroused by the thought of being female, which is also called autogynephilia. Feminine articles of clothing are stimulating because they represent femininity, not because the clothing is a fetish, although the behavior may have begun with the piece of clothing used in masturbation and/or sexual intercourse. The motivation to cross-dress may vary over time. Cross-dressing may have been sexually stimulating at one time, it now becomes an

act which reduces anxiety and produces a feeling of calm. According to the DSM-IV-TR, those with TF are heterosexual males. How the patient displays his cross-gendered presentation varies; some may wear women's undergarments under their suit, others may dress full time and wear makeup. Cross-dressing for the TF may begin in childhood but is not usually done in public until adulthood (574). For those diagnosed with TF, gender dysphoria can become a part of their identity as they may want to live full time as a woman and even obtain GCS. Gender dysphoria is based on a patient's self-diagnosis when objective evidence is absent. According to John Money, transsexualism signifies the use of sex-reassignment as a form of rehabilitation for the syndrome it creates: gender dysphoria. Therefore according to Money, one *is* a transsexual *if* they successfully pass the two-year, real life test of living socially, hormonally, and economically in the gender role opposite than the one they were given at birth prior to undergoing GCS, as outlined in the SOC. In this case, the therapist can diagnose one as TF with the subtype: With Gender Dysphoria. However, if one has all the criteria for both TF and GID, then they can be diagnosed with both (576).

International Classification of Diseases (ICD-10)

The International Classification of Diseases (ICD-10) is a list of general epidemiological diseases and their management. The ICD-10 includes information from health and death records, calculates morbidity and mortality rates, and incorporates the incidence and prevalence of various health concerns and diseases in relation to other social characteristics. Like the DSM-IV-TR, the ICD-10 can be used to diagnose patients; however, the ICD-10 is a medical document while the DSM-IV-TR is a

psychological document; some professionals feel that the ICD-10 is less stigmatizing to trans-patients. According to the SOC, there are five diagnoses related to gender identity disorders. While I feel it is important to touch briefly on the ICD since the SOC mentions it, I will not go into any further detail since U.S. professionals use the DSM-IV-TR and not the ICD-10 to diagnose trans-patients. A full comprehension of current theoretical, sociological, psychiatric, medical, and clinical knowledge is important to best grasp the research methodology and my subsequent findings regarding professionals understanding and decision-making processes. In this chapter, I have provided a brief exploration of the various ways that trans-identified people have been thought about, studied and classified in western modern history. As seen throughout, there are many ways that trans-people are defined and currently medicalized. In the next chapter, I provide details for how I studied the medical and mental health professionals who currently help trans-people hormonally and surgically transition.

CHAPTER THREE

METHODS

The purpose of this study was to investigate how medical and mental health professionals make treatment decisions with trans-identified patients. Using qualitative research methods, I conducted 21 in-depth interviews with professionals who have medically or therapeutically assisted trans-people to transition from one gender to the other. Mental health professionals, such as psychiatrists, psychologists, and licensed social workers and medical specialists such as family physicians, plastic surgeons, urologists, and endocrinologists are the people most likely to assist trans-identified people through transition. The World Professional Organization of Transgender Health (WPATH), the only professional organization focused on the medical and psychological needs of trans-patients, serves as a place for professionals in the field to discuss clinical, surgical, and research developments. Although some mainstream medical and psychiatric organizations have appointed special interest groups to handle the needs of gay, lesbian, bisexual, and transgender people, member numbers are small and do not produce the caliber of work that emerges from WPATH. I drew my sample from WPATH's membership as opposed to a sample the American Medical Association or the American Psychiatric Association, which would not provide me with people who had ever treated trans-people. Additionally, many professionals may have refused to treat trans-people or may not even have been of trans-identified patients in their practice.

Some health care workers, especially because the prevalence of trans-identified patients is low in relation to other patient populations, may not identify themselves as “trans-doctors/therapists” and so could not be isolated in larger medical/psychological organizations. While pulling a sample from WPATH may be the best choice since the majority of its membership is medical and mental health providers who treat trans-patients, it by no means includes health care workers who treat trans-people who choose not to join WPATH. However, I concluded that drawing a sample from the member list of WPATH was the best choice.

As a member of WPATH I have access to member information such as name, type of practice, place of practice, email, and phone number. While I could not pull a random sample, I attempted to reproduce one as best I could. My intention was to stratify by type of practice and then randomly sample from these groups. Initially, I also thought that I would only interview those who practiced in the midwest so that I could conduct a face-to-face interview. However, I soon realized that some specialties only included a few practicing physicians and there were not enough professionals in my immediate location to do the entire study. To ensure a large enough sample, I first decided to contact all the professionals in a large midwestern urban area who fit into the mentioned practices. I interviewed all those who agreed to assist in the project. Once I exhausted this list, I began to contact therapists and doctors in other U.S. locations. I attempted to meet with some professionals while they were in the vicinity; however, I had to result to phone interviews. Plastic surgeons and psychologists were the largest WPATH group of

professionals and were therefore easy to find and interview. I was only able to find one urologist who agreed to be interviewed. In total, I contacted about 60 medical/mental health professionals. Twenty-two agreed to be interviewed which provided me with a 38% response rate. Many of the WPATH member's either did not respond to me, were too busy to participate, or felt that they did not treat enough trans-patients to be useful for my study. However, I was able to interview at least one professional in each area of practice.

I also planned to recruit plastic surgeons from the annual Be-All convention which was held in the Chicago-suburbs in June 2008. This is an annual convention for trans-individuals, sponsored by the Chicago Gender Society (CGS). I had previously conducted exploratory research with trans-organizations in the Chicago area; therefore, I was familiar with the then president of CGS, Katie Thomas, whose approval I received prior to approaching the doctors at the Be-All about my research. I approached all surgeons who were speaking at the convention and while all agreed to participate, I was able to interview only one of them.

The biggest challenge in acquiring the sample was that so few medical and psychological professionals work with trans-people. Currently, no formal education for the treatment of trans-people exists, so there is no distinguishable group of practicing trans-doctors and therapists. Many medical and mental health providers who treat trans-people have "fallen" into the work. For example, some began to treat trans-people who were referred to them by a colleague or by one of their existing patients, who happened to transition while under their care. Therefore, many professionals did not feel qualified to

call themselves “trans-doctors/therapists” or did not feel they could offer much to my work. On the other hand, some whose practice was made up mostly of trans-people, usually because they had been treating trans-patient for some time and/or doing research specific to trans-issues, did not have the time to be interviewed. One interviewee requested that I email the survey and he would fill it out. He finally agreed to be interviewed after I discussed the purpose of my work and methodology, mainly the difference between surveys and personal interviews. Most professionals were interested in and saw value in my research.

Data Collection

After presenting project ideas and receiving permission from the WPATH president, Stephen Whittle, I contacted professionals via office email/phone as well as by sending a mass email through the WPATH listserv. In both email and phone contacts I explained that I was a student at Loyola doing dissertation work and the nature of the study. If they were interested in participating, I emailed them a copy of the informed consent, answered any questions and if they were interested, I asked them to please read, sign and send the informed consent back to me. The informed consent also included a box to check if they would allow me to audio record the conversation. Once I received the informed consent, I contacted them again to set up the face to face or phone interview.

I conducted 22 interviews. Ten were in person. Medical/mental health professionals who could be interviewed in person all chose to be interviewed in their office/home office. All but one interviewee allowed me to record the interview. Each

interview took approximately one and a half hours. I took only minimal notes during taped interviews because I could return to the audio recordings at a later date for a more accurate analysis. For the first two phone interviews I did not think I could tape record since I initially thought I would have a large enough sample to conduct only face-to-face interviews. For these un-taped phone interviews I explained to the interviewees that I would be taking notes and may need them to repeat an answer for clarification.

However, once I reviewed the applicable phone recording laws, I amended my research protocol, and gained IRB approval to tape record subsequent phone conversations with the interviewees' permission. Some states require that only one person in the conversation give consent to record while others require both parties' consent. Despite the individual state laws, I acquired written consent from all interviewees on the informed consent form and verbal consent on the audio recording at the start of the interview.

Each interview consisted of nine open-ended questions regarding professionals' knowledge of trans-people, decisions in treating trans-patients, and perspectives on difficult and rewarding patients. I used the interview schedule to stay on track and to ensure that I covered particular topics; however, I was flexible and allowed respondents to take the interview in directions they thought were important. I asked questions in a way that encouraged them to share concrete, detailed information on the treatment of trans-individuals.

Challenges

The main challenge of this research was that many times interviewees responded in the 'generalized present' about what they 'normally do' in medical encounters (Weiss

1994:71). However, I continued to push them to focus on specific examples to ‘tell me about the most recent time this occurred, or to walk me through this situation’. By probing, I felt I was able to get data, rather than interpretations. In initial interviews it became clear that requesting specific information perhaps made respondents uncomfortable as they did not want to reveal too much information about patients and potentially break patient-doctor confidentiality. However, while I continued to press for details of decision making about patients, I reminded them that I was not interested in patients and should they divulge information I reassured them that I would not reveal anything where a patients’ identity could be deduced.

While surgeons’ responses were often short and to the point, therapists and psychiatrists provided descriptive details and ‘inner events’ such as perceptions, cognitions and emotions (Weiss 1994: 75). I can only conclude that while surgeons only see their patients a few times surrounding a particular surgical/medical procedure, therapists engage in a longer and more meaningful relationship with their patients, therefore, being able to provide more information. Additionally, therapists, perhaps due to their training and experience, were more forthcoming. Finally, I feel that because therapists usually work in one hour increments, they had the full hour to spare for our interview while doctors perhaps fit me in between their often sporadic appointments.

Confidentiality

Although WPATH has roughly 600 members, those who treat trans-people are a small group, therefore easily identifiable. Medical health interviewees include plastic surgeons, emergency room doctors, urologists, gynecologists, family physicians,

infectious disease specialists, and endocrinologists. Many members of WPATH and this sample are plastic surgeons whose accounts reveal they are surgeons; therefore in these cases I may refer to them as such. Other categories of medical professionals are small where I may have only interviewed one person and present them as medical professionals, medical providers, medical workers, medical service providers, physicians, and doctors. Mental health professionals include psychologists, psychiatrists, licensed social workers, therapists, and psychotherapists. Although psychiatrists are technically doctors, I interviewed so few of them and their work with trans-people is similar to that of other therapists, I include them with mental health providers and will refer to them as such to protect their identity. I will refer to those who provide trans-patients with mental health services as mental health professionals, mental health workers, mental health providers, and therapists. I use these broad terms since I interviewed only one person in some categories of physicians and did not want to jeopardize anonymity. To protect respondents' identities, I also use pseudonyms for names, institutions and geographic locations. For psychologists, therapists, and psychiatrists I will refer to them initially using a first and last pseudonym for their name and subsequently only use the first name. For medical doctors, I will always refer to them with the title "Dr." with only their pseudonym last name. I also did not include a demographic chart which could compromise confidentiality. In the instances where I retained actual names, respondents' answers were common knowledge.

Interaction of Trans-patients, Medical and Mental Health Providers

Trans-identified individuals who want to medically transition from one gender to the other need both mental health and medical workers. Physicians who provide hormone therapy and surgeons who perform transformative surgeries, such as mastectomies, oriechtomies, and facial feminization, usually require that a patient obtain one letter from a therapist confirming they have gender identity disorder (GID). Surgeons who perform gender confirmation surgery (GCS) require two letters; at least one by a PhD level mental health worker, confirming a patient has GID and is appropriate for genital surgery. Trans-people who do not want hormone therapy or surgery often to provide what they call a “get out of jail free card”. This paper, written and signed by the therapist, indicates that the card carrier has been diagnosed with gender identity disorder. Trans-people present this card when their gender is in question, such as when a male to female trans-identified person is questioned for entering a female-only space such as a restroom. Therefore, trans-people seek out therapeutic relationships to help them with various life issues and to legitimize their cross-gendered feelings as stemming from GID.

Therapists usually know more than medical professionals about trans-patients since they engage in an on-going therapeutic relationship with them. Physicians, especially surgeons usually only see their patients briefly before and after a specific procedure. Medical workers, therefore, rely on mental health professionals’ perspective as to whether a patient really has GID and is thereby appropriate for hormones or surgical interventions. Therapists write letters to physicians and surgeons as ‘proof’ that a patient has GID and is therefore a good candidate for transitioning-related services. Although

surgeons may still do their own informal intake with the patient, the letters provide confidence that the procedure they are doing is appropriate and relieves them of some liability since by requiring this verification they adhered to the SOC.

Mental health professionals use doctors to learn more about the surgical and hormonal possibilities for their patients. During a therapeutic relationship with patients, therapists must help patients make the best decisions about if and how they will transition. In order for mental health professionals to do this, they must be informed of the various available procedures that are available, what patients should expect from surgical procedures and medical professionals, and how this transition may affect social, emotional, and physical aspects of their life. Mental health workers find that patients can be short-sighted when they decide they want to fully transition; they may have unrealistic expectations for their life post-surgery and for the surgical procedures themselves. Mental health providers acquire knowledge from doctors as well as from prior patients whom they have helped through the process.

Much of professionals' knowledge of how to best therapeutically and medically treat comes from their experience with trans-patients. With the limited scientific and social research, professionals must use clinical experiences as teaching moments. Additionally, through their involvement with trans-people, physicians learn ways to educate therapists and vice versa so that they can improve their collaboration and ensure a more successful process.

Conclusion

The methodological limitations and my subsequent interest in this project result because treatment of trans-identified individuals is, relatively speaking, new to the medical and psychological fields. Lack of knowledge and research in this area makes those who treat them, as one respondent stated, “cowboys” of the medical field. Professionals who treat trans-people are performing services that have little to no medical or therapeutic foundation outside WPATH, whose members themselves often disagree as to the best treatments. Mental health and medical providers are attempting to treat people who are not acknowledged in conventional medicine or society, often using medical and therapeutic procedures many in mainstream medicine would call unethical. With this project, I show how professional knowledge is created, transferred, and institutionalized.

CHAPTER FOUR

FORMAL AND INFORMAL KNOWLEDGE

Professionals must find ways to acquire skills they need to effectively assist trans-patients since to date, no formal academic program specific to trans-people exists. Some institutional programs offer elective courses focusing on GLBT issues, although most respondents complained that these rarely addressed the medical or mental health issues of trans-people. Often instructors had little to no experience working with trans-people. Participants, who were interested in learning more about trans-patients, used class assignments, medical rounds, and internships to specifically focus on trans. This chapter uncovers how respondents worked to fill the clinical and medical gaps that could not be met by formal education. Medical and mental health providers self-educate through interactions with patients and colleagues, through trial and error, and by accessing outside resources. In attempting to learn more about trans-patients, professionals support, change, and create new trans-related knowledge.

Formal Training

Few institutions offer training specific to the treatment of trans-identified patients. Some find offering such programs is not cost-effective, especially since members of the mainstream medical community are not always in agreement as to how or if trans-people should be treated, or since trans-patients are a relatively small percentage of overall

patient populations. Many doctors and therapists may not want to treat trans-people, for personal or professional reasons. According to Dr. Eric Friedland, deciding to treat trans-patients can be career suicide, although for him, being a ‘cowboy’ in the medical field is precisely what drew him to it. However he states “Oh no, I never had any formal training. There was never any formal training to be had.” Brett Zelman, a therapist, confirms that medical doctors lack the appropriate training to treat trans-people:

On the medical end, one of the doctors in particular, did a lot of consulting with an MD in the area that was very knowledgeable on hormones. He had a much better handle on the medical end of hormones and administering hormones. They weren’t trained either, on the medical end, in their programs. And I’m assuming that he spread that knowledge about the hormones to the medical staff, I’m assuming. In the clinical...in the psychotherapy staff, there was no formal training that took place but lots of attention given to what are we going to do with trans-clients who are wanting hormones and not necessarily not wanting psychotherapy? What are we going to do with the kids coming in wanting hormones? There’d be peer consultation on that and things of that sort. They’re not equipped. They’re not equipped. So the sorting out of “is this person appropriate and ready for hormones?”

Dr. Bill Sanders finds that the lack of education may be a result of disinterest in treating trans-people, especially since medical institutions do not overtly support it:

You can’t make an academic career treating trans [people] so, the academic institutions are not really interested in doing that [offering trans-related programs]. They’re not you know. You can hire a guy and make a career out of treating cancer. You’re not going to make a career out of [treating trans-patients] you know in the United States. In Europe they do but, here they don’t because it’s not supported social policy.

Since no formal educational institutions provide programs specific to therapeutically treating trans-individuals, many mental health professionals were encouraged to enter sex therapy programs or programs which had a GLBT focus, as Kathy Grayson explains:

There was at that time in history they recommended in the standards of care that you become a certified sex therapist to do this work because it was the closest curriculum. And I became certified through AASECT (American Association of Sexuality Educators, Counselors, and Therapists).

When professionals are encouraged to enter related programs, the assumption is that sex and gender are one in the same. Perhaps because of this lack of formal training about transsexuality and *gender* concerns, these are inappropriately confused with *sexual* concerns. Many professionals recognize that these programs did not specifically meet the needs of their trans-patients as Kathy explains:

No, it [obtaining information specific to trans-needs] is still additional. To me early on it seemed like a real gap in the knowledge and training of a general therapist. I think it is an important part of life...well just like I said because I was working with a lot of couples [I] realized that people were having sexual difficulties and I didn't know much about what to do and it didn't seem like there were many places to refer them and I found out that the University of Washington right where I was in Seattle had this sexual dysfunction clinic and training program so there I was. There are probably even fewer [programs] back then. So it is very limited. So it just depends on where you are in school. Like if you are in Indiana University at the Kinsey Institute you are more likely to get some lectures and couple classes that deal with sexuality but if you are somewhere else nobody there is interested or knowledgeable enough to do it.

Aside from the lack of programs, existing programs lack the knowledge or interest in providing information. In the above quote, Kathy recalls only two institutions which provide some type of coursework or focus on sexuality more generally.

If trans-issues are incorporated in a program, they are usually combined in a more general GLBT course. Many professionals, such as Diane Olsen, find that transgendered-related education is not included. If a course does address trans-people it rarely provides enough information to prepare medical and mental health professionals to competently treat trans-people. She states:

But I don't know that there is [sic] [programs about trans-issues]. If anything it wouldn't be just trans, it would be under a GLBT umbrella. There is [are] probably a few programs now but there wasn't when I started in 95. Even in GLBT the T is usually dropped off so it just seemed like transgender people that were the few groups of people that were there hadn't been a real push to understanding these folks experiences. Even within the GLB communities there is a lot of prejudice and misconceptions.

Brett Zelman provides another example:

And usually in those classes [GLBT] the T gets shorted. And this is an elective class. So first of all, not everyone is taking it. It's usually preaching to the choir.

When courses did not offer the information professionals hoped to receive, many had to incorporate them, as Natalie Hatfield shares:

And when I went back into psychology that was always part of my specialty so throughout class and when there was class projects and things like that often times it would have a GLBT bent. The training, the practical training, all of those sites actually for the therapy piece were with people who were involved in mental health with trans-folks.

Many times instruction dealing with trans-populations is assumed to overlap with gay, lesbian, and bi-sexual groups or they are left out completely. Often their lives are presented by a non-trans person who has limited exposure to trans-people. Therapists feel the 'T' should not be included under GLB as they are not similar medically, psychologically, or socially. Trans-individuals have different needs which require unique treatments and social networks not shared by gay, lesbian, or bi-sexual people.

When programs do not offer continuing education about working with trans-patients, they may offer occasional workshops for service providers to receive training specific to treating trans-patients. However, some professionals, like Rita Roberts, criticized these programs:

[In the training, I expected] Real life experience with real life transpeople. I think it was, I can't remember the name of the woman but she wrote a book on gender. It was very academic and I don't know, I felt like, my perception was very much about the 'other', those people and that is off- putting when I think about therapists getting together to talk about that group of people I think is very distant. I would have included if there was a transgendered therapist who was willing to sit down and talk with other therapists. The fact that [it] wasn't part of the planning, it was about let's talk about that person. I think it would be a difference. I also think as a lesbian, I am a little past educating other therapists. Whatever. So I think there is a way to include and be inclusive without sort of exceptionalizing. Here is the transgender therapist. You know, I think that is patronizing, but I think it is at the beginning stages.

Rita found the workshop to be too academic and presented the trans-patient as an object rather than a subject with agency, thus the program did not offer the education she felt would be useful. Lack of formal training impacts professionals' ability or inability to effectively assist trans-patients. Formal education that does exist assumes gay, lesbian, bisexual issues are similar to those experienced by transsexuals, confuses gender-related concerns with sexual concerns, and may not be useful to the goals of particular professionals who need the information.

Initial encounters with trans-identified patients did not come during formal education but rather with providers' first job in the field. Natalie Hatfield learned the most by supervising students who happened to have trans-clients:

Because I did in-services with them and one was specifically about trans and what to look for. It's interesting because at first I felt strange because I had not actually spent time with trans but what I was realizing was, was because I had the opportunity to supervise so many students who were treating so many trans-people and went to workshops and did a lot of reading that my knowledge was far superior unfortunately, to many clinicians out there. So I was still able to provide a lot of good information to, like their staff, for instance.

In a similar manner, Joseph was first exposed to trans-patients when he obtained a job at a clinic:

But I didn't treat any until I started my first position, post doctorate degree. I had learned about gender identity issues in my internship, in that year of training. So I worked in a sexual disorder clinic and had some gender patients, so that is when I first saw them. But I didn't treat any until I started my first position, post doctorate degree.

Perhaps one of the reasons why formal education and training is deficient is because the history of transsexual medical and mental health knowledge has a short lineage. The fields of psychology and medicine did not view trans-individuals as worthy of attention until about sixty years ago and professionals did not view them as deserving medical attention until the work of Harry Benjamin in the early 1950s. In addition, the population of known transsexuals is small compared to other types of patients so having specific programs to treating trans may not make financial sense for an institution. Another reason that organized education and training is non-existent may be because many debates exist between professionals about how to diagnose and treat trans-people as I show in this chapter.

Informal Knowledge

Finding Resources

Due to the lack of formal training, professionals find that in order to appropriately treat trans-patients they have to do their own legwork in accessing useful resources.

When asked how staff who Brett Zelman, a therapist, worked with were able to improve the ways they treat trans-people, he replied:

I think it was a very individual matter. Some people were willing to talk, to do peer consultation. Some people were willing to read books and articles. Some people had more of a natural feel for it. And some people, none of the above.

Brett's response, although not exhaustive begins to shed light on the various approaches professionals have to take to get the knowledge they need to better help trans-patients.

Rita Roberts, a therapist, must be pro-active and creative in acquiring much-needed knowledge:

As a therapist I don't feel that in order to work with someone that is a heroin addict I don't need [to be an addict], [sic] that I learned tremendously from people that I see, you know. I'm affiliated with, over the years, different professional organizations. I read, [and] talk to people. So it's probably self, in terms of the issue, the issues connect in the discrimination, the process, the terminology, the standards of care, all of that would probably be self-education. I do think that the process with working with somebody regardless of whatever spectrum they are around gender issues is really a process of identity and I think it is very important for me that I know the literature, the medical stuff, I have an active referral network. I write letters. Well there is a whole educational process but I also [know] that there are resources around. Part of it is I think there is resources part of it is on the therapists I think to do the research whether the internet or what is around. There is stuff around.

Rita explains that the connections she has made are due to her initiatives networking with different people and organizations. She feels it is the therapists' job to access information to help patients, even though little information is to be found. Many professionals use the internet to stay updated on topics related to trans-individuals.

Natalie stresses the importance in knowing about local resources, not so much that they exist but which ones are in fact, trans-friendly:

I would say what I can do is different just because of things like the internet that there are at least in this metropolitan area more places to refer people to so I don't have to be someone's sole means of support. And so I don't know if that necessarily changes what I do with people but it makes me feel more comfortable in a sense. So you know comfortable so that I walk a line between like when a

transwoman says she wants to join a book group and I know that Lilly's Bookstore [name has been changed] has book groups for women. I have to keep in mind depending on how this particular client looks and how comfortable she feels really being in the world as a woman that may or may not be a good place to suggest for her to go and even if she does pass well and is secure in her identity that it still might be, it's not like she's walking into a trans space.

Many times professionals seek out support networks for their patients so that the patient does not rely entirely on them for assistance, relieving the professional of both time and pressure involved in treating trans-patients. Natalie continues to indicate that staying current on professional discussions about trans-people is important as other institutions are affected by such knowledge. She mentions to one of her clients who cannot continue aspects of her transition because it goes against her parole rules. Transitioning, the patient tells Natalie, would be grounds for the parole officer to return her to jail. Natalie states:

So I'm always walking that line but I'm lucky that I have resources and that we have resources in the area. So that is helpful and I would say 3 years ago I wasn't up on the whole autogynephilia thing. So and that's again it hasn't changed how I am with people but my ear is open to, if someone starts talking about like with this parole officer. This client and I have had a few discussions about how the parole officer got information about autogynephilia and that is why she's pushing [telling patient she will revoke parole if she continues to dress as a female] this client so much. And it [has] made me kind of educate myself to make sure I am even more educated on different aspects. I just feel like since the trans community has access to information because there is information now within the trans community of professionals that I think is actively working against trans-people, I feel more of a pressure then to keep up on as much as I can. And because as a whole this is a group of consumers that really stay up on things. So I'm going to lose credibility if people are coming to me and saying I don't believe that autogynephilia stuff and I respond "Well what is that?" I guess I'm a primary transsexual even though I don't believe in those terms so sometimes I'm scrambling and I'll go to other people that I know and say "Have you heard this term before?"

Treating trans-people is difficult when knowledge is not there or difficult to find. It is important for professionals to feel that they can help their patients; therefore, they believe they should know at least as much as their patients. Wanting to help and to be perceived as someone who *can* help creates pressure for professionals to find outside sources of information. Having as much or more knowledge than patients increases professionals' authority and credibility with their patients. Additionally, professionals feel that they have to stay on top of the medical, psychological, and legal knowledge concerning trans-patients as changes in this knowledge can create and limit opportunities for trans-people and ethically guides the ways they are allowed to treat. Many also want to stay abreast of information because many trans-patients do their own research and internet searching. In trying to protect and legitimate their professional authority, professionals want to have more information than their patients.

Interactions

Many respondents indicate that their understanding of trans issues and decisions they make with patients stems from their ongoing experience with patients and colleagues.

Interactions with trans-patients

Information gleaned from the medical encounter informs and guides medical and mental health providers' decisions. Patients, given the lack of medical knowledge and consensus over trans issues, often teach professionals what it means to be trans-identified, how to best care for them, what treatments are available, and in what manner they should

be administered (Dewey 2008). Since formal knowledge is difficult to find, patients become the experts, as Dr. Nicole Pruitt explains:

I mean it's like when you get diagnosed with a disease you become an expert at it. I have a patient who developed leukemia and that patient knew more about treatment for leukemia than I did. He just, you just become an expert. You scour the internet information and you just want to eat it all up and just, this is me and I want to know why I am like this. I was struggling to find answers that are not there.

Trans-people may even be the catalyst for why a professional may enter the field, as Diane Olsen iterates.

In the early 80's I had a friend that was going through transition from female to male. And it was somebody who I knew their girlfriend and then met them and I was working on a doctorate in applied research and they said "Oh you are going to be a psychologist? I think you'll find this interesting. I think I am going to do this [transition from female to male]". And they explained it to me. And at that point, there were no resources for trans men at all so this person did all kinds of publicity stunts to get the word out that he wanted to meet other people like by going on the Howard Stern Show because there was no internet or things like that. Then we used my apartment to gather people together and it became a support group that ran for many years. I met hundreds of people and their partners and other people in the community and finished my dissertation and doctorate and realized that they needed clinical, they needed clinical psychologists. And then I went into a post-doctoral program to become a clinical psychologist to work with trans people and I did sort of everything along the way. The beginnings of our community, here from a little support group to knowing all the doctors, all the professionals, and all the therapists and involved in all the conference as they came into being...so I've done everything from the ground up. I'm a grass roots person.

Since Diane's friend was transitioning from female to male, Diane not only acquired the formal education she needed to clinically treat trans-people, but started a support group, initiated professional conferences, and enlisted the support of colleagues.

Medical and mental health professionals' clinical experience with trans-patients is often valued over formal training, if any even exists, as Diane Olsen explains.

That requirement [to treat trans-patients] at the time was like getting a Masters. It was so many hours. And I went to Matthew Kline [names have been changed] who is here in _____ and I went to him for supervision because you need a certain number of hours of supervision from somebody who is certified through AASECT [American Association of Sexuality Educators, Counselors, and Therapists] but honestly I knew so much by the time I did that because of my experience in the community that it was really a formality.

Formal training may provide the official documentation needed to practice but experience gives professionals the credibility and ability to treat patients. Due to the absence of easily-available, evidence-based research, professionals suggest that experience is a crucial piece of their knowledge, both in treating patients and socially interacting with them within the doctor-patient relationship. Diane continues:

I rarely find anything that I haven't encountered. They [patients] are confirming what I see. And it just makes me think that if you see enough people, we are all going to see the same thing. If you are very open.

Along with experience, practitioners must also be receptive to what patients tell them as Dr. Alex Boyd recognizes when he states "I think it is a matter of listening to patients' stories, peoples' stories." Brett Zelman agrees but also adds another tool he thinks is useful:

I listen to my clients. Do I need to know what causes transsexuality? Not really. I really feel no need to know that. I need to feel like I trust my intuition that what this particular individual really needs for a solution to the dilemma is a different body.

Since patients' stories and experiences help professionals to better understand gender-related issues and assist their patients, Dr. Pruitt reiterates how crucial it is to be open to these:

Well it is interesting because the first person I ever treated actually helped me transition [from male to female. He [respondent's patient] started seeing this

therapist for this [being transgender] and that kind of made me think “Could I be something like that?” and I had to tell him [her doctor] that I was a physician and that I looked this way and it was the most, I can’t tell you how agonizing that experience was because I have had patients who told me how when they went to the emergency room they didn’t feel like the doctor, didn’t understand anything they were saying and degraded them and I felt that way. This person [the physician this respondent saw while going through her own transition] did the worst exam and had to do a rectal exam and he was just awful and all I wanted to do was get out of there but I thought I was dying and needed a CAT scan and it was after that I decided I needed to have a one [a stable doctor]. I know what it feels like to be behind the bus. I mean I never experienced prejudice you know, I’m Caucasian, come from a Catholic family, and now and then as soon as I came out I was all excited about what I knew about myself. I realized the rest of the world didn’t feel that way. Now just even the craziest stories I try to say “Well could that be possible?” Nothing is cookbook for me anymore. Because people have different stories to tell and if you don’t listen, you don’t get it. And not just about transgender, but lots of things, pain syndromes, things that don’t make sense. Just because another doctor can’t make a diagnosis doesn’t mean the patient doesn’t have a real problem. Especially when I was a young physician, if a person didn’t fit a diagnosis in a text book well they were just crazy or we would just pass them off. But I hang in there with them and try and I may not be able to get them an answer or I can’t give them an answer and sometimes it takes a couple years before something becomes evident but I never, I don’t come across them anymore like there is nothing wrong with you cause there could be.

This listening, she explains, helped her “get it” and forced her to apply individual rather than “cookbook” treatments to her patients. Through her interaction with a former patient and her own challenges as a trans-patient, Dr. Pruitt acquires vital clinical skills which structures future medical encounters she has with patients. Both inappropriate treatment by other professionals and her own difficulties with transitioning helped her have more patience relating to trans-people. Rather than rush to fit her patients into a specific diagnosis, Dr. Pruitt is willing to take time to listen and find the best label and treatment plan even if she cannot find support in official medical documents.

Through trans-patients' request for particular treatments, professionals may begin to use treatment options not previously administered. Dr. Eric Friedland learned about hormone therapy when a trans-patient came to see him for a non-trans-related medical problem after her own doctor refused to treat her:

She says "What about my hormones?" We'll deal with your hormones later. She said "But my other doctor won't deal with it". She asks "Can you learn about hormones?" I said sure. This was the push. So when I told her that I don't have a problem with it [providing hormones] but I do need to learn a lot more about it in order to help you safely [sic] they were overwhelmed... "Oh, my god!" They had found the trophy that I was able to help them. So that was the initiation.

Like Dr. Friedland, Nicholas Thomas, a therapist, learns through his patients:

The limited number of transpatients I've seen they are very good with familiarize themselves with what ever kind of literature, whether it be scientific or lay literature and anything they can find that has been written about it they know about it they can tell me more about hormone treatment than I know.

When particular trans-people request or educate their doctor about what they want, professionals begin to learn about certain medications. Dr. Martin Callahan, initiated by a patient request, began to perform a new surgery:

This patient was referred to me by a colleague that did SRS [sex reassignment surgery] and asked me to feminize her forehead. I never thought about that before. Never even thought men and women's foreheads were different.

Specifically, because of this patient, Dr. Callahan began a long journey of self-educating, researching, and writing about the sexed differences of the human skull. This request pushed him to research the bone structure of the face so that he could improve his facial feminization surgeries. Dr. Frank Jolsen explains how his interaction with patients impacted his skills:

I had some experience in my residency with genital reconstruction as applied to not only to the trauma or cancer patient, but also to the trans-gender patient. My experience as a resident did not involve leading a team, screening patients. I was basically involved in the surgical elements of it: learning the surgical approach to these patients, learning the anatomy, and getting some familiarity with what is possible surgically.

Sometimes treatments are not necessarily new, but are different as applied to the trans-patient. Dr. Jolsen shows how skills pertaining to genital surgery used on genetic women for trauma-related issues could also be applied to natal males undergoing GCS. Doctors' clinical and surgical experience with trans-patients allows them to imagine new medical options and improve their bedside manner. Whether formal education is limited or seen as less valued than clinical experience, professionals seem to agree that the manner in which they medically, therapeutically, and socially approach people derives from their experiences of listening and interacting with "expert" patients. Professionals can base their decisions on official diagnoses as found in the DSM, on patient behavior, or a unique combination of the two. Understanding which one of these guide professionals' decisions, provides insight into how they may relate to their patient and reveals the relationship between medical knowledge in texts with medical knowledge gleaned from the medical encounter. What professionals learn from patients can be just as important as, and alter, existing medical knowledge.

Interaction with other professionals

Professionals also interact with colleagues to provide well-rounded care for patients and to assist each other in making difficult treatment decisions as well as giving the support they need to engage in controversial work. In addition, by connecting to

others, professionals are able to access information that may benefit their patients, such as advanced surgical techniques, better after-care treatments, or professionals in other disciplines who are willing to treat their patient. Dr. Alex Boyd discusses this need:

I work in a multi-disciplinary fashion. We have a clinical psychologist as well as a primary care physician. So, the three of us work in concert.

Since trans-patients have needs that cannot usually be met by one professional, interaction between professionals is pertinent. For patients to receive particular medical remedies, they must be diagnosed by at least one therapist, yet patients may also need treatments such as GCS or hormone therapy requiring the expertise of various doctors as Joseph Anderson, a therapist, explains:

Right, that was because they (other doctors from a gender team) came to me because they needed a psychologist specifically to do evaluations and treatment for the gender dysphoric patients that they were getting... These were surgeons, one was a gynecologist, one was an urologist, a plastic surgeon, [and] one was an endocrinologist so there was actually a gender team at the hospital.

All these professionals recognize the multi-disciplinary needs of trans-identified patients.

Dr. Eric Friedland, on advice from another colleague, reiterates:

This is not rocket science. This is really simple. It is like treating thyroid except there is an emotional component to it, a psychological component to it. And a surgical component. Stratifying these patients you have to work in concert with the surgeon and psychologist or psychiatrist.

Multi-disciplinary teams can also assist and hinder trans-patients. While professionals working together can make the process of obtaining services more efficient for patients, they can also create a monopoly on services, institutionalizing the gatekeeper role. Dr. Friedland feels that his collaboration with a therapist is good medical care, yet

also reveals his power to manage and judge more than the medical aspects of trans-peoples' lives:

We have discussions about all of these patients which makes it that much richer and [the] ability to really follow patients well and “Are they ready for the next step? Where are they at? Where are they at maturity wise?” Mentally, physically, that is the piece I'll give to (other professionals).

Many professionals discuss patients whom they believe are not appropriate for services. When professionals collaborate, they can make it more difficult for patients to convince other care workers to give them the treatments they want.

Many providers approach their colleagues to obtain advice on best practices in treating patients. One such therapist is Nicholas Thomas who stresses that his area of expertise is limited and he likes to practice evidence-based medicine:

Yes, I mean I like to practice evidence based medicine. None of the trans-people that I treat am I dealing specifically with the gender identity. Yeah, I'm not familiar with that but Margorie Smith has written a couple of books so I read those or I can do a literature research but I don't know that anyone has any official organization like the APA or sub committee has progulmated any type of standard of care when it comes to addressing gender identity. It's either you get the surgery or you don't. You take hormones or you don't. Or whatever. So yeah, it would come up a case by case basis I think. I would be on the phone with Margorie or pulling a book or doing a literature search.

Some professionals connect with others to find out the strides made in their area of expertise so that they know possible interventions, as Dr. Callahan states:

Endocrinologists ...I talk to him, other doctors. Dr. Jones (a surgeon) will tell me things about her success, like the quality of her results of changing voices. Dr. Johnson (also a surgeon), he will talk about his changing voices. He's in _____. Dr. Smith, complications he sees with people that have surgeries in other places. He does SRS [sexual reassignment surgery].

Dr. Jonathon Walters adds to this point when he adds:

Some of the HIV medications made it very difficult to do a bunch of stuff because they [trans-patients] are always taking a lot of pills. I learned hormone replacement from a couple of old doctors who worked with transgender people and had retired. And that is sort of how I learned hormone replacement stuff. I knew them from when they were this all happened in the 90's and I met them in the 80s. So I knew them and they said if you ever have problems just call. The HIV stuff is easy to learn because there is a lot of stuff on the internet and conferences. In general for hormone replacement in transgender kind of stuff I tend to call other doctors who are interested in it.

Dr. Susan Morgan also received training through the mentorship of other practicing doctors:

I met Dr. Jones years ago, and he said “You could do your general practice while I train you and teach you the other stuff.”

For some professionals, their observations of other professionals helped them develop their own approach to treating trans-people, as Nicholas Thomas illuminates:

Well when I was medical student doing my surgery rotation... I happen to scrub in on a couple of sexual reassignment surgeries [and] I sat in on an interview] where a senior clinician would come in and interview a patient with all of the psych residents observing. And Mark Rosatti [name changed] came in and interviewed a transgender patient and who was seen by one of the residents I believe on an outpatient basis and I distinctly remember how mean he was to this person, condescending, I remember I don't know if the patient had transitioned or not but she was male to female, very long hair, long fingernails and she came in and sat down and she had not had a mammoplasty done yet and he looked at her and he goes “Looooong, loooong, nails” in a really nasty way and I remember being struck by that and not liking him.

Respondents may, after seeing trans-people being mistreated by professionals in the field, alter their approach to patients. Sarah Elan explains:

Alex Johnson [name changed] did a lot of preliminary work with gender people—as early as 3 years of age they recall being in the wrong body—girls playing with boys stuff and vice versa. They can remember parents chastising them. They go through school and with puberty many try to fall in the cracks and go into gay relationships but are not happy with it and 20% of guys decide well I will become a macho person and join the military. Johnson saw many go into Vietnam period,

many came back a mess and to a hostile society. My patients were criticized for being in Vietnam and trying to express their identity. I was a young faculty member and had a lot of trouble with the gender patient. [sic] [I] wasn't really prepared with everything these folks have gone through. Johnson was so dynamic and his patients loved him. He put up with a lot of excentricities. Many looked like the most awful transgender, overdid the makeup, hair, pretty gaudy individuals, Alex was very supportive.

The previous two accounts reveal how prior observation of other professionals helped these psychiatrists to be more open and compassionate toward future patients.

Many doctors initiate relationships with other professionals so that their patients can receive surgical after care. Only a few surgeons in the United States perform GCS; most trans-people must travel to others states. Unfortunately, many doctors do not know how or do not want to treat trans-people, especially those who have just received GCS. Surgeons may refuse to perform GCS on a patient who does not have a doctor to manage them post-surgery. To address this problem, some physicians will contact doctors in their patients' home town in order to set up after care or put pressure on insurance companies to find after-care, as Dr. Jolsen shares:

It can be (difficult to find docs to treat patients). In this case, I was working through the insurance company and I just told them, ya know, handle it. I'm not doing it unless you can provide a doctor to provide post-op care at home. The patient is not moving to Florida forever, the patient is coming from Washington state or wherever it was. They found the proper people that would look after him when he got home. And that's the only way that's doable [sic]... [through] conversations. We get a list of names of providers and we say, "Hi I know you're an urologist. Do you have any interest in this? Do you have any experience in this? This is kind of what we need from you. Can you do it?" I'm the coordinator for everything.

Dr. Jolsen, like others, spends considerable time ensuring patients will have the medical support they need post-surgery by attempting to make contacts with other providers in

their patients' area. Dr. Susan Morgan clarifies the process by which she increases her network of colleagues:

Well, one thing we do is we try to get them to see [a medical or mental health professional]. We have networks of people around the country. So we can usually find them somebody, if not in their neighborhood, [and] then reasonably close to get them. We know of doctors throughout the country, we kind of have a database that has sometimes been helpful in getting people care, [sic] [meeting] patients needs and just meeting doctors around the country. People that have come to us and have said, "Look, I take care of trans. I'd be happy to take care of your patients". Or they themselves are trans and are practicing in the Philadelphia or New York area or whatever. So, you know, write their name down. Actually, sometimes it's as simple as, I met this doctor one time, and he just seemed to be... I just met him at a party, of all things, and he kind of came up to me and said, "Hey, you know what? I'm a cross dresser, but I'm an OBGYN and I work at such-and-so, and if you need patients you can send them to me." And I'm like, "Oh, that's helpful." Because, ya know, they're not necessarily trans, but they're you know, you've got that...at least they have that much insight and compassion that they're not going to shy away from treating a person as a human being.

Professionals, in order to best assist their patients and relieve themselves of the pressure of feeling they are the only one who can help a patient, must network with other professionals. They accomplish this by attending various conferences and through the WPATH listserv. Sometimes, professionals, like Dr. Friedland, are asked by patients to educate their current practitioner:

I have a lot of doctors [who] that contact me from far places. A patient has come to me and says "Can you please talk to my physician? She really wants to help but doesn't know how." I say, "Here is what I am going to do. I'll write it all up. Here are the notes. Take it back to your doc and have her give me a call."

Many patients work to educate their doctors rather than find a new, more accepting practitioner because their current medical professional is convenient and has been caring for them for a long time (Dewey, 2008). Dr. Nicole Pruitt explains how doctors contact her to assist in finding resources for trans-patients:

Oh, yeah, well they connect with me because I do all this reading and know all the networks. There is an endocrinologist who works at Main Hospital. She has some patients too and she often calls me and asks me “Who do you send them to for this?” or “Who is a good therapist?” Things like that. She hasn’t been in town that long and I’ve been here a lot longer. I know people.

The professionals in this study wanted to work with other professionals so their patients can receive necessary care. They are interested in sharing information so that other medical and mental health professionals can appropriately treat trans-people and to ground their decision making within a community that supports the work they do with trans-people. Interactions between medical and mental health professionals are forged by both the professionals themselves and through patients. Professionals feel that trans-patients, perhaps unlike many other patients, have many unique needs. Professionals also feel that since the pool of willing and able professionals is small, they are required to provide more of their time and work to help the trans-patient. Additionally, the work that they do is unconventional and sometimes seen as unethical. Therefore, professionals choose to collaborate with their colleagues to effectively meet patient needs, legitimate the decisions they make, and efficiently accomplish “good” doctoring.

Trial and Error

Professionals learn how to best treat medically, surgically, and therapeutically through trial and error. They also, over time, find that they are better able to distinguish patients most suitable for treatments. Many treatments used for trans-patients already exist for non-trans patients. While various forms of plastic surgery and hormone therapy are already available to non-trans patients, performing them on trans-patients is relatively

recent and usually initiated and perfected by a small selection of practitioners, such as Dr.

Eric Friedland:

And he was using hormones for various genetic malformations and said “hey why can’t I do this for my trans-population and can I do it in a safe way?” So it’s very, it’s almost trial and error. You know the way I came across it first do no harm, what hormones, what do they do, what do we want to affect, and what is our goal?

Professionals also feel that much of how they assist trans-patients comes from years of watching others do the work and repeating particular tasks, especially in transformative surgeries. In order to learn how to perform these professionals must observe and perform surgeries with other professionals, as Dr. Bill Sanders discusses:

So I mean I’ve been like you know like you would educate yourself about anything else you read, you watch somebody do the work and then you if the opportunity came along to gain experience actually doing it.

Dr. Frank Jolsen reiterates this point:

I mean, my knowledge has changed in that I am constantly improving my surgical skills, I am constantly improving my efficiency not just in the operating room but in meeting people and transmitting the information they need. That’s really all it is. And it goes along with the ways my surgical skills have improved over time. Surgery is a contact sport. You can’t just read a book and be a surgeon. You have to feel it, taste it, touch it, operate on it, [sic] [and] see how the scar forms. My efficiency in the operating room improves daily and my efficiency speaking to people improves daily.

Through trial and error, professionals are able to improve both surgical and social skills. Additionally, medical and mental health providers refine the manner of deciding which patients they will work with. Service providers, like Dr. Jolsen, want to be successful and part of that success depends on choosing the right patients:

I guess the biggest improvement in my transgending, that’s a good verb, is that I’m willing to tell people go away, “I don’t like you.” Hasn’t happened that often, but I am very able and willing to do it. I have a very low threshold for turning

them down if I don't like them...I think about them (things he wants to learn). I synthesize knowledge based on my own experience. There's not a lot out there.

Diane Olsen, a therapist, also reveals that her intuition in choosing her patients has improved.

I'm a better and different therapist than I was but that is just experience...I think I'm more comfortable because I am not a beginner you know you are going to be more comfortable. And more, it's so vague, and more skilled. I think I'm very much better at instinctively knowing who is going to be more difficult to work with but that is not always helpful because I most often work with them anyway. And that can be very difficult but I have a very good sense of who that is going to be. I can see because I have worked with so many hundreds of people I know very often how people are going to adjust. So I just have better vision and I know that is probably not a very good answer because you want more concrete things. I started out so open and I am still open how to do it... I also just thought of things that I do better now. People will...I usually know from the phone call. There is a certain thing that happens on the phone where people you know there is an energy or people are needy. There is neediness but there is a complaint. It is hard to explain because somebody else could do or say exactly the same thing and it wouldn't give me the same feeling.

The two previous accounts show how experience improves professionals' therapeutic and surgical skills. In addition, experience equips professionals with the tools to intuitively know what kind of patient someone will be; while the latter professional indicates she will work with difficult patients anyway, the former feels that a mark of his skill improvement is his ability to recognize and turn away patients who may pose problems.

Trial and error also forces professionals to fill particular gaps within the field.

Some of these gaps include meeting patients' overall medical needs and conducting long-term research. Sarah Elan, a therapist, expounds on this point.

A lot come back to us for hormones but some get them from other places. I try to get them to come back once a year to get data on long term-follow up and that's why I go to WPATH meetings to see what happens long term with hormones. We have never had one of our patients with breast problems, cancer. I don't do rectal

exams and I wonder if I should. I don't have long fingers, but should I recommend them to someone else? We are getting better, educating our doctors. I am not sure how many psychiatrists do the medical management that I do. One thing about us is that we really stay with our patients. I try to set up with endocrinologists and say "You need to do this and this." I think of them as my long term patients. I stay with them [patient]. I'm hoping estrogen therapy will keep prostate from getting cancerous but I don't know if it does.

Sarah not only attempts to collect her own data but also attempts to meet all of her patients' medical needs by doing some of the medical care herself or connecting them to physicians. Sarah, through lengthy engaged relationships with her patients, believes she can learn about the long-term effects of hormone therapy and to better manage patients who are taking hormones. These experiences prove crucial in improving with patients.

Conclusion

Due to the lack of formal training, professionals find other ways to acquire the knowledge they need to adequately treat trans-people. For some, this interest comes during their formal education as they individually choose to focus on trans-people for class papers or medical rounds and clinicals. Some, however, do not receive information about trans-patients until their first place of employment. It is from this point that medical and mental health workers must do their own work in securing the information needed to meet patient needs. Since their work is rarely supported by mainstream medicine they have to forge their own connections to like-minded colleagues and learn by listening to their patients.

Knowledge acquisition differs for every professional, therefore, creating many disagreements within the community of care workers and produces different approaches to treating patients as I will show in the next chapter. Medical and mental health

providers, because their knowledge is so varied, attempt to work their decisions back into formal knowledge forms, such as the DSM and SOC, to bring legitimacy and credibility to their decisions, build professional repore, and solidify strong relationships with patients.

CHAPTER FIVE

PROFESSIONALS' UNDERSTANDING OF OFFICIAL
DOCUMENTS USED IN THE TREATMENT OF TRANS-PEOPLE

Medical and mental health professionals use the Diagnostic Statistical Manual (DSM-IV-TR) and the Standards of Care (SOC) when making treatment decisions about trans-identified patients. However, as I will show throughout this project, while their decisions actually emerge from broader cultural beliefs about what makes a successful male and female in our society, they attempt to align their choices with the SOC and DSM for legitimacy. The DSM-IV-TR, used by U.S. professionals in the treatment of trans-people, provides diagnostic criteria for psychological disorders while the International Classification of Disease (ICD-10), used mostly by European health care workers, consists of medical diagnoses. The SOC are clinical, medical, and psychological guidelines for the management of transsexuals or those diagnosed with gender identity disorder (GID) as specified in the DSM-IV-TR. “All three documents attempt to set uniform standards for medicine that interact with legal, medical, social, and state concerns about how medicine is and should be practiced” (Matte, Devor, & Vladicka 2009:43). The SOC and the DSM are based on professional agreement derived from clinical experiences rather than scientific research, and because professionals continually alter them based on changes in medical and societal views, they are considered ‘living’ documents (Matt et al 2009: 43).

ICD-10

The International Classification of Diseases (ICD-10) endorsed by the World Health Organization (WHO), is a list of general epidemiological diseases and their management. The ICD-10 includes information from health and death records, calculates morbidity and mortality rates, and incorporates the incidence and prevalence of various health concerns and diseases in relation to other social characteristics. Like the DSM-IV-TR, the ICD-10 can be used to diagnose patients; however, the ICD-10 is a medical document while the DSM-IV-TR is a psychological document; some professionals feel that the ICD-10 is less stigmatizing to trans-patients. According to the SOC, there are five diagnoses related to gender identity disorders. While it is important to touch briefly on the ICD since the SOC mentions it, I will not go into detail since U.S. professionals use the DSM-IV-TR and not the ICD-10 to diagnose trans-patients.

DSM-IV-TR

History

Mental health providers use the DSM-IV-TR, published in 1994, to identify and diagnose patients with various disorders, including those with GID and transvestic fetishism. The DSM-IV-TR provides diagnostic uniformity for professionals to communicate and conduct research. The first DSM was developed in the early 1900s and in 1927 the American Psychiatric Association (APA)¹ supported the DSM since it felt the International Classification of Diseases (ICD-6) lacked scientific proof. However, it was

¹ Some professionals inappropriately assume the DSM is a psychological, rather than a psychiatric document.

not until 1952 that the APA actually published the first DSM for professionals to use in lieu of the then, ICD-6. Although the APA developed the DSM as an improved tool over the ICD-6, it continued to give input to the WHO for future versions of the ICD. This cooperation between the WHO and APA reveals the relationship between general medicine and psychiatry (Matte et al 2009:44).

Purpose of DSM-IV-TR in Identifying and Treating Trans-People

Currently, two diagnoses found in the DSM-IV-TR pertain to trans-identified individuals: GID and Transvestic Fetishism (TF). The Harry Benjamin International Gender Dysphoria Association (HBIGDA), now called WPATH, added transsexualism to the DSM-III in 1980 (Matte et al 2009:44). In 1994, the DSM changed its diagnosis of transsexualism to GID. According to the DSM-IV-TR (1994), a patient is diagnosed with GID upon proof of intense and persistent feelings of being the opposite sex (also called cross-gender identification or gender dysphoria) and is continuously uncomfortable in the assigned sex but cannot have an intersex condition. The DSM-IV-TR also lists early cross-gendered childhood experiences as criteria for those with GID (DSM 1994:576). For example, the DSM indicates that a young cross-gendered boy will have a ‘preoccupation with traditionally feminine activities’ and will attempt to dress in feminine attire. Under GID, one can either be diagnosed with Gender Identity Disorder of Childhood, Adolescence, or Adulthood, or those who do not meet these criteria receive the diagnosis of Gender Identity Disorder Not Otherwise Specified (GIDNOS) (SOC 10). The DSM differentiates between GID and those who simply do not conform to traditional

sex roles, since for patients diagnosed with GID must display all parts of the syndrome (576).

TF, another diagnosis used for cross-gendered patients, is listed under paraphilias in the DSM-IV-TR and describes TF's as sexually aroused by the thought of being female, also called autogynephilia. Feminine articles of clothing are stimulating because they represent femininity, not because the clothing is a fetish, although the behavior may have begun with the piece of clothing used in masturbation and/or sexual intercourse. The motivation to cross-dress may vary over time. Cross-dressing may have been sexually stimulating at one time, yet becomes an act which reduces anxiety and produces a feeling of calm. Usually those diagnosed with TF are heterosexual males. How the patient displays cross-gendered presentation varies; some may wear women's undergarments, others may dress full time and wear makeup. Cross-dressing for the TF may begin in childhood but does not usually in public until adulthood (574). The DSM-IV-TR indicates gender dysphoria may emerge for some diagnosed with TF as reflected in the disappearance of sexual gratification associated with dressing and their desire to live full time as a woman and obtain gender confirmation surgery (GCS). Surgeons will only perform GCS on patients diagnosed with GID by two mental health professionals. Therefore, patients diagnosed as TF would have to be re-diagnosed once gender dysphoric behaviors emerged. Some surgeons may even require a GID diagnosis to perform other surgeries such as facial feminization or voice surgery.

Professionals make treatment decisions based on a patient diagnoses. According to the SOC and to most, if not all, doctors and therapists, only patients diagnosed with

GID should transition to the other gender, especially when those who want GCS.

However, according to John Money, gender dysphoria is based on a patient's self-diagnosis when objective evidence is absent and transsexualism signifies the use of sex-reassignment as a form of rehabilitation for the syndrome it creates: gender dysphoria.

Therefore according to Money, one *is* a transsexual who successfully passes the two-year, real life test of living socially, hormonally, and economically in the gender role opposite to the one given at birth prior to undergoing GCS, as outlined in the SOC. In this case, the therapist can diagnose one as TF with the subtype: With Gender Dysphoria.

However, one who has all the criteria for both TF and GID can be diagnosed with both (576). Money's work shows that the SOC and DSM should both be used together to treat trans-patients, introducing the opposite of the officially supported diagnosis-treatment process. Although patients should be diagnosed and then receive treatments as specified in the SOC, the reality is that professionals diagnose based on patient information and sometimes diagnosis confirmation comes after the patient has successfully transitioned as outlined in the SOC.

Current DSM Debates

One of the main debates among professionals for the upcoming DSM-V, to be published in 2012, is whether GID should be removed from the DSM. Proponents of GID exclusion argue that people with GID are neither psychologically disordered nor treated. Those with GID are often treated medically through surgeries and hormone therapy, therefore GID should be a medical condition, not a psychological disorder. Opponents of GID exclusion suggest the new DSM-V should be empirically grounded,

making it a more useful tool for professionals in distinguishing between those who have GID and those who have TF or autogynephilia. Many also claim that the DSM should include GID so that trans-people will have official legitimation as they seek insurance coverage and come out to family and friends.

SOC

History

The SOC were first developed in 1977 by a committee of American clinicians and professionals, including one transgender activist, while attending the 5th International Gender Dysphoria Symposium. Soon after, this group created HBGDA, now WPATH medical and psychological professionals who treat trans-patients, as well as students, researchers, and activists, trans and non-trans alike. During this same meeting, the committee drew the first draft of the SOC (Matte et al 2009:44). WPATH members continually revise and approve versions of the SOC, now in its 6th edition. The SOC were developed to benefit both trans-identified patients and professionals. The SOC respectabilizes and professionalizes medical and mental health providers' work with trans-patients. The SOC standardizes the treatment of trans-people, thereby improving communication and research between clinicians and scientists.

Purpose of SOC in Treating Trans-People

The SOC are guidelines many mental health and medical professionals use to assist patients in transitioning from one gender to the other. Although the SOC indicate that professionals should use it as guidelines, it also mentions that the steps should be a minimum expectation. According to the SOC, patients should be diagnosed as gender

disordered as specified by the DSM or ICD-10, prior to living full time in their desired gender. The SOC also specifies that GID patients should live as the desired gender for at least 3 months prior to hormone therapy and 12 months prior to undergoing GCS. Trans-people seeking hormone therapy or reversible surgeries such as breast removal must have at least one letter from a therapist confirming their diagnosis while those wanting GCS are required to have two letters of verification, at least one from a PhD level therapist.

Current SOC Debates

With previous versions and with the 7th version, WPATH members' main concern is that SOC language fails to appropriately reflect medical research and thus pathologizes trans-patients. One way of professionalizing the work of those who study and treat trans-people is to develop set definitions. Earlier versions of the SOC deferred to both the ICD and the DSM criteria for diagnosing patients. Some professionals began to realize that their method of diagnosis and discussion in clinical practice was not aligned with the language in the DSM or ICD. For example, in the DSM-III, the diagnosis for transsexualism did not include intersex individuals. However, the SOC-III during this same time stated that it followed the DSM-III but then later in the same section of the document clarified that it did not exclude intersex persons from the diagnosis of transsexualism. WPATH members may have experienced internal inconsistencies in developing versions of the SOC because they were attempting to create clinical guidelines using diagnostic language. Therefore, version 5 of the SOC excluded the diagnostic terminology used in the DSM and retained only ICD-10's diagnostic criteria of "gender identity disorders". Many viewed this term as more inclusive and reflective of

trans-patients experience than the former “transsexualism”. Committee members, however, did not provide an explanation for eliminating DSM criteria from the 5th version of the SOC. They argued that clinical practices were the impetus that led to the exclusion of prior pathologizing DSM terminology used in the SOC and the inclusion of the term gender identity disorder (Matt et al 2009: 45).

Other medical and legal terms which provide legitimization and justify treatment but simultaneously pathologize patients are “disease” and “disorder” (Matte et al 2009: 46). Some therapists, doctors, and patients feel these terms present patients as sick or in need of correction rather than as a variation of the human experience, as supported in trans-related research and suggested by Harry Benjamin. Therefore the SOC must consider the various ways people understand their gender identity and not assume that all trans suffer from identity *disorder* nor should suffering be a prerequisite to being diagnosed with GID. The current version indicates “To qualify as a mental disorder, a behavioral pattern must result in a significant adaptive disadvantage to the person and cause personal mental suffering.” This point stems from the DSM-IV and the ICD-9. GID patients may or may not experience mental anguish, depression, or anxiety related to their gender identity, but may feel this way due to discrimination, prejudice, and mistreatment by others, not because they have gender identity variance (GIV). Therefore, professionals should consider replacing the term “disorder” with “variance” since GIV reflects a part of human diversity rather than a disease or mental disorder (Winter 2009:34).

Another way the current version of the SOC ignores the various ways trans-individuals identify and present is by indicating that there are ‘two primary populations with GID—biological males and biological females’ (section 1). According to Winter (2009), SOC language pathologizes because it is insensitive to transpeoples’ GIV. Words such as biological male and female deny individuals self-identification and are not medically correct. Winter argues that since biological sex has five components: brain, genital, gonadal, hormonal, and chromosomal, a person who identifies as female but was labeled male at birth may be at least partially biologically female based on the other four components. The SOC should incorporate terms which are not only scientifically correct but inclusive of all transpeoples’ identifications, such as ‘female-identifying transperson or transwoman’ (Winter 2009:35).

A final problem with SOC’s language is that it is not inclusive for non-Western trans-identified people. Despite the fact that WPATH is an international organization, it was not until 1990 that the initial introduction of the SOC removed the term *Americans* and *U.S. citizens* from its first two sentences. Since versions of the SOC were created by Americans and Western Europeans, the language and purpose reflected and addressed only Western trans-related concerns. While version 5 did include a section addressing culturally different manifestations of gender identity disorder, it did not acknowledge that the application of treatment could differ based on these various gender expressions. Those involved in the upcoming 7th edition are considering altering the language and treatment to be more culturally inclusive to consider the needs of the patient and minimize terms which pathologize. Additionally, many believe that developing more

standardized terminology provide for higher quality data collection and improve communication between patients, practitioners, and researchers (Matt et al 2009: 44).

Many WPATH members' concern for the upcoming 7th edition is that its contents be empirically grounded and universal. Many professionals are concerned that what they know about transsexuals and the best way to treat them is not appropriately studied, and therefore not reflected in the SOC. Professionals argue that the prevalence of people with GID and other identity variances, as well as the epidemiology, or patterns and factors that lead to GID should be used to revise the SOC. Until methodologically sound research is available, service providers use their personal observations of trans-patients. Perhaps if the contents of the SOC were empirically supported, then professionals would be more likely to adhere to them. Some want a more internationally accepted document to ensure that all practitioners are following the same standards and provide an opportunity for professionals to be licensed or credentialed a "gender specialist". Qualified, well-trained gender specialists, would be more equipped to treat trans-people, thereby eliminating an over-reliance on the DSM and SOC, especially the expectation that treatment is contingent on GID diagnosis.

Professionals' Use of the DSM-IV-TR and SOC

Medical and mental health providers' comprehension and use of the SOC and DSM-IV-TR structures how they relate to patients, make treatment decisions, and interact with colleagues. Professionals may see the purpose of these documents and apply them differently but all incorporate them in the course of their work. Therapists and doctors rely on the DSM-IV-TR to distinguish 'real' transsexuals from transvestites and those

with autogynephilia and to determine who is qualified for particular medical treatments. Others suggest that GID should not be in the next version of the DSM since it is not a psychiatric condition, but should be somewhere in the medical nomenclature such as the ICD-10. Using these guidelines promote respect from colleagues, lessens chance of blame or suits from patients, thus legitimizing professionals' work.

Identifying 'Real' Transsexuals

Professionals use DSM criteria to diagnose patients. The DSM differentiates between those diagnosed with GID and those diagnosed with TF. Many professionals agree with the SOC that only patients diagnosed with GID qualify for hormone therapy and transitioning-related surgeries, especially GCS. Janice Nelson, a mental health worker, explains how she determines whether a patient has GID or TF.

Well, for cross dressing there is a sexual gratification link, and often times the person has no desire to change genders, it's just like a fetish. You know once those female clothes come off or once the male clothes come off... it's usually male to female. It's usually men wearing female's clothes I should say when it comes down to cross dressers that's just the way it ends up. But, so then I will try to make a determination and I'll say okay and I'm using different tools and questions that I am able to figure that out (whether someone is has TF or GID). And then when I say to them 'okay if I could waive a magic wand and turn you into a woman full-time and you had to go through A, B, C, D, E, and risk all this fallout would you do that?' Cross-dressers would say, 'absolutely not. I am totally fine being a male. I just like [to] dress up and get off being a woman once in a while.' A transgender person would say, 'I'll do anything. I'll do anything to be my true gender.' So there is a huge difference there, and there usually isn't a sexual link (for those with GID). If there is, it usually goes away once they are able to start transitioning.

Janice distinguishes those with GID as people willing to be the other gender full time despite the many risks to their personal life. She identifies those with TF as people comfortable being their assigned gender, whose cross-dressing has a sexual component,

and are not willing to make personal sacrifices to be the opposite gender. Janice believes that a sexual link may exist for those diagnosed with GID but that it will likely disappear with transitioning; however her view is not supported by the DSM or the SOC which states that a professional should not administer hormones or allow surgery unless a patient is first diagnosed with GID. The DSM does not mention that one with GID may have a sexual component that should subside with treatment. Rather, it states that individuals can be diagnosed with TF even if they develop a gender dysphoria component. In this case, one would be diagnosed as Transvestic Fetishism with a subtype of With Gender Dysphoria (575). Janice's account reveals how professionals either do not fully understand or rework the medical/psychological knowledge in a way that fits with their understanding of these documents. Since many professionals look for a sexual component to diagnose then patients will often deny any behavior or minimal connection to sexual feelings or gratification out of fear of being denied a GID diagnosis and subsequent treatments.

While some understand and use the documents literally, Joseph Anderson, a therapist, argues that this thinking has changed over the years:

Well, one big change is that the notion of gatekeeper has changed dramatically. So when I started and I think this was true of the prevalent attitude in the professional community at that point, again 23 years ago there was much more of a sense there is the true transsexual or the primary transsexual is what they called it. Then there is the secondary or obviously being the false transsexual. Back then, particularly when it came to MTF transgendered folks, it was believed that the true transsexual, MTF transsexual was someone who was effeminate in childhood who was attracted to men and was essentially what we call now the homosexual or androphillic transsexual. And that if you weren't that then you were what they call a secondary transsexual called the transvestic transsexual, back then there was a distinction between the homosexual type and the what we

call now the autogynephilic type. And it was believed that the true transsexual is the appropriate person for surgery, and this other type or transvestic type was not. Well that changed pretty quickly and I wrote and presented on this issue arguing against the typology of true transsexual versus a not true transsexual. And so I think I and the whole field has kind of moved away from the notion that there is some kind of a true form of transsexualism. You have to understand that there are many different forms of transgender experience. So that is one big change.

Acknowledging many forms of transgender experience may benefit or hinder trans-patients ability to access medical treatments depends upon the next version of the DSM-V and how professionals understand and apply this knowledge.

Currently, one of the debates about the upcoming DSM-V is whether a new identity called autogynephilia should be added. While this term is mentioned under the current TF diagnosis the new version would separate autogynephilia from TF. The autogynephilic are natal males who experience erotic interest when imaging themselves as women. According to Blanchard, who coined the term, autogynephilia is present in all non-homosexual male-to-female transsexuals (2005); however, only some respondents stated they agreed with this view. The difference between those with TF and autogynephilics is that TF's do not wish to change their gender while the autogynephilics do. While those diagnosed with GID want to transition because they believe they *are* the opposite gender autogynephilics want to transition because being the other gender is sexually gratifying. Joseph Anderson, a mental health professional, finds that the way the DSM is currently written allows anyone who wants to transition, regardless of why should be diagnosed with GID. He argues that autogynephilics should be separated from androphilics or those who truly have GID and whose desire to transition stems from a gender, not sexual need.

Again there are 2 types, 2 main kinds of men who want to become women. Androphyllic type are the homosexual type, the boy who was effeminate as a child would dress up as a female but would not for the purpose of sexual excitement. They would mimic the females around them. They are attracted to males and sort of had a gay lifestyle orientation for a while but they don't want to be with a male who is interested in them as a male but they want to be with a male, preferable a straight male who wants to be with them as a female. So that is the androphyllic type. The autogynephyllic type and again very consistent history, this is a boy who is not effeminate, not a sissy boy like Richard Green² studied, so typically masculine in play behavior, dress as a child that he in adolescence even before puberty often would begin to cross dress and begin to put on female clothing interestingly it is under clothing. Then during adolescence and he would do this because it was soothing. Again if you get the history with these folks, they experience the cross dressing with mothers, sisters panties as producing a sense of calm. That in adolescence the fantasies of being a female are eroticized ok, so autogynephylia means self sexual arousal. So it is being aroused by the fantasy of being a female. This is what is behind the majority of cross-dressing. This is what transvestites have, right. And some of those people also want to change their gender and this is the majority of MTF transgender folk. I believe [they] have this component that at some point and this is crucial they were aroused by the fantasy of being a female sometimes it is the fantasy of having breasts or clothes, the role, the fantasy or image of being female is sexually exciting. Now at the same time these people are typically heterosexual attractions, sexual relations and even married to women because they also have that component to their sexuality. But at some point it is not enough for them and they want more. This is I think the tough part and why Mike Bailey³ got into trouble. I think he kind of reduced that kind of trans-experience to paraphilia which I think is incorrect. That is... That is why people got pissed off. That is why trans-people in the community see that as pathologizing their feelings. And they reacted in ..But the fact is still indisputable that the majority of these folks at

² For more on Richard Green's work see Green, R., & Money, J. (1960). Incongruous Gender Role: Nongenital Manifestation in Pre-Pubertal Boys. *Journal of Nervous and Mental Disease*, 131, 160-168.

³ For more on Michael Bailey's work see *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* (2003). Many have and continue to challenge his work as pseudo-science which disparages trans-people as nothing more than men who want surgery to either have sex with other men or because they have strange autosexual desires. For more on this see University of Michigan professor Lynn Conway's investigation of his work on her homepage at: <http://ai.eecs.umich.edu/people/conway/TS/LynnsReviewOfBaileysBook.html> or for more on the controversy, see Alice Dreger's review *The Controversy Surrounding the Man Who Would Be Queen: A Case History of the Politics of Science, Identity, and Sex in the Internet Age* in *Archives of Sexual Behavior*, 2008, 37:3.

some point have been aroused to the fantasy of the female. With my experience and what is interesting is that the female identification often comes before the sexual excitement. So often these are kids at 5, 6, 7 have this feminine identification that then becomes eroticized. I believe it is a combination of identity issue and a sexual phenomenon.

Joseph states that many patients and some professionals interpret autogynephilia as a paraphilic trans-experience where sexual excitement precedes female identification. This is why many trans-people feel that including autogynephilia in the DSM will reduce their identity to TF, a sexual paraphilia rather than an identity which stems from a cross-gender concern. However, Anderson believes that for the autogynephilic, female identification comes *before* sexual excitement. Regardless, many professionals still feel that separating autogynephilia from GID or androphilia reduces transsexuals' identities and feelings to only an erotic experience and demonizes those who have sexual desires as Natalie Hatfield, a therapist, explains:

Oh ok, well at this point [there] is this whole strand of autogynephilia now. I think that the research has been really shoddy. And we are looking at a population that has tried so desperately and allies have tried so desperately to get to a point where people are finally accepting and not putting it under sexual paraphilia and now we have a group who are saying that they are allies and really suppose to be top researchers in the field and they are coming out with this theory that is making a subgroup of people who are transgender into people who have a sexual paraphilia. So it is actually kind of ironically is that the biggest problem I have is that this subset of clinicians and researchers that are very involved in trans issues as opposed to most clinicians that don't know anything. I have the most problem with people who are VERY involved with trans issues who are really pushing this autogynephilia thing as opposed to clinicians who are just ignorant and haven't thought about the issues at all.

Natalie's frustration is that if the DSM-V includes autogynephilia it will cause a large portion of trans-identified individuals diagnosed with GID under the current DSM-IV-TR to be re-diagnosed and identified under the section of the DSM titled Sexual Paraphilias.

The implications of this not only affect identity but it can also limit patients' ability to obtain insurance coverage or medical services currently only allowed to those diagnosed with GID. This therapist is also frustrated that these empirically baseless 'theories' are coming from professionals who are supposed to be helping trans-people. Prominent researchers can both legitimize and de-legitimize trans-people.

The DSM indicates that those with GID have early childhood memories of being in the wrong body. Due to this, medical and mental health professionals often use this criterion as one way to distinguish true transsexuals from either those with TF or some other psychological issue, which usually disqualifies patients from transitioning services as Dr. Boyd points out:

I remember that an individual had been seen by a therapist but one of the things we always have to watch for in plastic surgery is body dysmorphic disorder [BDD] so things just didn't quite add up right. We asked the individual to see the psychologist who was quite convinced that the person had body dysmorphic disorder as opposed to gender identity disorder...sort of a recent shift not the life long sense of being trapped in the wrong body. That is a very common theme as I said people say 'ever since I can remember something wasn't right'. This seemed to be someone who kind of had a revelation much later in life and it just didn't seem like the other patients we had been treating.

Dr. Boyd judges whether one is a true transsexual by DSM criteria. However, he also uses his experience with other trans-patients as evidence in which to judge his current patient. Since this most recent patient did not fit the 'common theme', Dr. Boyd believes that perhaps this patient has BDD instead. In actuality, professionals make diagnoses decisions based on what patients tell them. Deciphering whether one is a true transsexual is based on what patients tell doctors as Dr. Friedland explains:

If this patient comes in with a story. This is not affectation. Who the hell would want to go through this misery?...This is not an affectation, not a choice like I think I'll put on blue today, as opposed to green...It's a self-diagnosis that is why physicians have such trouble with it because they cannot x-ray you, they cannot give you a questionnaire.

In the absence of physical symptoms, medical and mental health workers must base their decisions on what patients tell them. However, many trans-people are familiar with the DSM and SOC making professionals wonder how much of what patients tell them is real or just an aligned presentation with the documents to obtain a GID diagnosis and particular medical treatments. Aware of this fact make therapists' jobs difficult as Joseph Anderson shares:

Yes and well I can't blame them. They are creating a story of themselves that they believe fits with the identity. And fortunately again this is getting better because there was a time when people would come in and I would begin the session with 'look you don't have to prove yourself to me.' Because people would come in with these canned stories. They read the literature and they knew back then if they said that they were aroused or used to cross dress as a kid in adolescent then they might not get surgery. They were very careful so again I always begin an interview with someone like that who comes in gender dysphoric by saying look you do not have to prove it. Just tell me your experience. You know it is your option to do what you want with your life. I'm not going to stop you.

Professionals, such as therapist Natalie Hatfield, understands why patients may be dishonest in the ways they present themselves in order to get their needs met:

I mean if I were in their shoes and I wanted something very, very badly and knew that I had to go through someone to get it, I would present myself in a good light. So that to me is not someone being manipulative or anything like that. I really believe that people have a right to make their own choices about their life. I'm actually very uncomfortable being the gatekeeper.

Professionals must find ways to get the truth from patients so they can make proper diagnoses. For most, trans-identified people are not seen as genuine if they do not have a

life long story of struggle with gender issues. Patients' stories are framed by DSM criteria, especially since many professionals use the DSM to make diagnoses and treatment decisions. The more professionals see patients whose stories are aligned with DSM criteria, the more likely they are to believe that the DSM is a good diagnostic tool. Therefore, patient stories, truth or not, legitimate the DSM. Following the DSM, yet trying to get patients not to take it into consideration when they approach medical and mental health providers must be a difficult task. The specifications in the DSM limit the existence of identities and only allow certain paths for patients to realize those identities since surgery is strictly allowed for those with GID. Although some, like therapist Diane Olsen realizes that patient identities cannot fit into the rigidity of identity definitions found in the DSM:

I think it is broadening because it is a completely diverse population of people. So there is no end to the different personalities, different backgrounds, lifestyles, different identity configurations. I came into this with the understanding that there was no one way to be trans, no one way to transition or to define your life.

Interestingly, trans-medical knowledge as found in the DSM, is consistently being re-worked within the doctor-patient relationship through the doctoring process. The DSM impacts the decisions professionals make. Professional-patient interaction introduces unique situations which can challenge professionals' knowledge of trans-patients. With new versions of the DSM being developed in the next year or so, professionals are hoping to change the DSM to better reflect the ways they are already treating their patients. However, even if the DSM is updated, it will not necessarily alter how professionals use idiosyncratic criteria for identifying 'real' trans-people, as Dr. Bill Sanders explains:

I find that the true Trans the fear is for a true Tran, I'm not worried about a true Tran suing me because they really do better when they have the orchiectomies [removal of the testes for natal males transitioning to female, reduces testosterone]. That's a sign that they were a true Trans. So if you get somebody who isn't a true Trans or that has some sort of underlying psychological issue, it's not the true Trans [I] am really[worried] about being sued by. That's why I sit on the psychological evaluation, I want to make sure this is a true Trans and not somebody who is confused or has some psychosis or something else going on.

This professional shows support for the DSM, diagnosing, and psychological evaluations.

By wanting to be a part of the evaluation, he further shows the need for collaboration between surgeons and therapists. For him, he must ensure that patients are 'true' transsexuals so they do not sue him. However, he also states that if a patient 'does better' after removal of the testes then they are true transsexuals. Therefore, confirmation of a proper diagnosis comes after he has performed surgery.

The expectation that trans-people need to be diagnosed as a 'real' transsexual impacts how professionals identify and treat trans-people. The DSM-IV-TR states there are differences between those with GID and TF, mainly that sexual and gendered feelings are mutually exclusive and treatments should be provided only to those who are diagnosed with GID. More recently, professionals are discussing a new category, autogynephilia, which could change many individuals' diagnoses from GID to a form of TF, affecting access to transformative treatments. Most professionals support the DSM in identifying patients who have GID and the SOC in administering particular treatments while others find that these documents hinder trans-peoples' right to self-expression and access to available medical care. Patients also have access to the GID and SOC and therefore, align their presentation to their health care providers with the criteria in these

documents, ensuring they receive the diagnoses and treatments they want. It is this reality which also affects how providers accomplish their work as I will soon show.

Grappling with DSM Diagnoses and Language

Some professionals believe that GID and TF diagnoses are necessary to identify, research, and treat trans-people. In order to meet patients' needs others wonder why a diagnosis is necessary to provide medical and therapeutic treatments to those who want it. Another question is whether GID and TF should be listed in the DSM, a psychiatric document, since the treatments desired by many patients, such as hormones and surgery are medical, not psychiatric, solutions. Various health providers and patients alike find that simply including these diagnoses in the DSM, in addition to the language the DSM uses to describe TF and GID, indicates that trans-people are mentally disordered.

Through interactions with patients, many professionals are beginning to feel that those who identify as cross-gendered are not mentally ill but because they have early memories of being in the wrong body their condition is genetic or biomedical. Some, like Dr. Susan Morgan, find that gender dysphoria results from medical rather than psychological conditions:

And that was one of the biggest abuses I saw in the system, making a person who had lived...first of all, it's not psychological. So I very quickly became convinced of that. That actually came out as one of the changes that was a really big one. To say, 'Look, this doesn't seem to make sense. People are telling me that this is the way they've felt since they were three, four, and five years old' and you know, we're being told that it's a psychological condition, in other words they're half crazy kind of thing. So quickly it became apparent to me that it's something that is hard-wired in the individual, when they've felt that way since birth, pretty much. And that's the vast majority of patients who feel that way. So, it's not psychological.

Dr. Morgan suggests that gender dysphoria, especially since many patients claim early onset of cross-gendered feelings cannot be defined as psychological. Dr. Morgan infers that to be diagnosed with a psychological disorder is to be “crazy”, whereas a trans-identity is more stable and “hard-wired”. This view is quite common and inadvertently stresses the importance of early childhood feelings of being transgender as part both of the diagnosis and the stories which trans-people present to their therapists and doctors. Interestingly, the DSM-IV-TR lists early childhood memories as criteria for GID; therefore Dr. Morgan’s argument reveals the contradiction in that the early-onset criteria mentioned in the DSM, a psychiatric document, does not seem to support a psychological problem but one of genetics or biology⁴.

Medical and mental health professionals who feel GID is not a mental illness still find that leaving it in the DSM is the only way patients can receive therapeutic treatments. Dr. Nicole Pruitt, a family physician, explains:

I don’t think it is really a mental illness. I think we are all just really confused at birth. And but most of us suffer from society, that in our society you are either male or female so there is really no between so we suffer from that and from depression and so by leaving it in the DSM we can get psychological treatment because I still see my therapist. But we also legitimize it as a psychological disorder so like homosexual is not considered a psychological disorder anymore so I mean you can’t claim that to get treatment from a psychologist. You can say you are depressed, but not that you are homosexual. So it just, 35% of transgender people have problems keeping a job...society just can’t accept anything [sic] but you are male or female and that is it.

Professionals are conflicted about including GID in the DSM because while diagnoses are needed for patients to receive treatment, they also signify that they have a

⁴ The DSM is a psychiatric document since it was developed by the American Psychiatric Association. However, many professionals interchangeably use the terms psychological for psychiatric.

psychological disorder. Dr. Pruitt explains that much of trans-peoples' problems stem from society's expectations and that trans-people seek therapy not so much because they have concerns about their gender identity but because society, the people in their life, are not accepting of their gender. Dr. Pruitt, like many others, argue that the only way to provide therapeutic services trans-people apparently need is to have it listed in the DSM. Although Dr. Pruitt mentions that homosexuals can not receive treatment for being gay, they can for depression; however, she does not think that diagnosing trans-people with depression is sufficient as she continues to lean towards inclusion of GID in the DSM.

Brett Zelman, a therapist also reveals this conflict:

It's the only thing in the DSM that has the cure of medical intervention. Which makes it a very curious animal. Um... (pause) as long as folks need letters from therapists to be able to have surgery, they need to be able to afford therapy. As long as that's the case, the only way insurance companies are going to cover the cost of therapy is to see that there is a DSM code or diagnosis. So that the reality is that many people need to have the diagnosis still in the book...I don't think that apart from when I have done a hormone letter I have ever diagnosed anyone with GID because I don't consider it a psychopathology.

Brett, although against using the GID diagnosis, recognizes the need for GID in the DSM because as long as surgeons and therapists require them to go through a particular number of therapeutic treatments in order to receive the medical interventions they want they have to be able to afford it. This means they must be diagnosed as that is the only way companies will cover it.

On the other hand, Joseph Anderson does not feel that a patient needs a GID diagnosis just to obtain psychological services.

It becomes sort of the flash point of the debate. Is this a disorder or not? And the dilemma is there are advantages to having it labeled as a disorder mainly to get

treatment covered and there are disadvantages to having it called a disorder because people don't like to be told they are nuts. So that's going to be where this is all going to get all fought out in the near future... if physicians care about this again we need to separate medical and mental health care. [Currently] This is a mental health diagnosis. I don't see the issue in terms of adults needing it as a diagnosis to get mental health treatment.

Aside from receiving insurance coverage and obtaining therapeutic services, Joseph realizes that being diagnosed with GID pathologizes his patients. Professionals and patients want legitimation for cross-gendered feelings, for it to be recognized as real and as worthy of access to psychological and medical treatments but not as a disorder. As Joseph explains, feeling like the opposite gender does not make one disordered but being uneasy or dissatisfied with cross-gendered experiences does.

I'm still thinking this through myself but I am at the point that I think, like homosexuality, we need to take it out [of the DSM]. The disorder is not the gender, it is the dysphoria. It is the unhappiness with one's gender. So we have to have some way to address that and get treatment for that without labeling it as a disorder. Again I'm not sure how we are going to do that.

Joseph shows, retaining GID in the DSM may be possible if we change the DSM terminology which describes those with GID.

Professionals often struggle with DSM language and what it implies about trans-patients. Joseph suggests using new terms that do not indicate a disorder.

Gender dysphoria is not a disorder in my book it's a symptom, a definition. Gender dysphoria in my mind simply means that one is unhappy with their given gender. So that does not constitute a disorder in my mind but it is the reason they come in, right? They wouldn't come in unless they were unhappy with something. In this case they are unhappy with their gender.

Language becomes important in the debate about GID in the DSM. Professionals know that this phenomenon exists since trans-people have real problems associated with it.

However, gender dysphoria should be viewed as a reason why someone might want professional help rather than an indication that they are psychologically impaired. Trans-people seek out professional assistance to help them deal with their gender concerns. Professionals and patients need some type of label to discuss this with others, as Sarah Elan, a mental health provider explains.

It's a syndrome. It's a phenomena [sic]. Is it a disease or condition? I don't know. I think we need it [in the DSM] otherwise how would you get insurance to pay for it? How could you explain it to family members? Its causing a person distress, panic disorders, that is in the DSM.

Sarah continues by questioning those who do not think it should be in the DSM.

What is it about it [the diagnoses in the DSM] not being there? "We're normal people." But what is normal. You don't want the genitals that God gave you.

Kathy Grayson argues that language is important because its meaning sends messages about appropriate ways to treat people. Therefore, she calls for clear terminology in order for psychologists such as herself to make clinical decisions.

I think for a general psychologist it is kind of confusing about well is this a disorder? Are these signs of pathology that we need to try to talk people out of or get people to accept themselves?

Professionals grapple with if and how GID should be presented in the DSM. Including this diagnoses in a psychological document and the terms that are used to explain it structures how professionals make medical and therapeutic decisions with patients. It also impacts trans-people's experiences with medical and psychological institutions as they attempt to access treatment, affecting how they may present themselves to professionals. Finally, diagnoses and language have larger implications which impresses upon trans and non-trans-people, what it means to be transgendered.

Diagnoses serve practical functions, providing mutual language between professionals, patients, and insurance companies. Joseph explains this nuance.

Well that is [there are] lots of debate about that [whether GID should remain in the DSM or not] as you know from reading the WPATH emails. Tremendous debate/argument about that. I just got an email from a transperson that is very involved in this and he sent out a description of a motion at the AMA to essentially, to get the AMA behind that this is a medical condition for which the treatment is hormones and surgery. So on one hand you have that sort of push in the professional community in order to get insurance coverage. So one of the main reasons it has been in the DSM IV and may still be in the DSM V, we'll see, one of the main pushes from the trans community is to include it as a medical disorder so they can get medical treatment approved by insurance. Again as you know the past 25 years insurance companies have resisted paying for treatment and I have spent many hours fighting for patients to get insurance approved treatment for hormones, psychological treatment for the surgery. Insurance companies for many years have specifically excluded it. Some if you fight them they will back down and cover it but it is pretty rare. So again we have two competing forces here. On one hand you got professional and trans community pushing to medicalize it if you will, to say it is a medical condition and therefore should be treated with medical options and those that medical treatment should be reimbursed by insurance. On the other hand you have another force saying this is not a disorder and removed from DSM V and you have these competing forces working and as professionals I think we often get caught in the middle. Our problem is how do we on the one hand advocate for getting medical services for trans people while at the same time removing the stigma that is attached to it.

Many professionals can see the benefit and the problems for patients and for treating them by retaining GID in the DSM. The dilemma is that insurance companies need diagnostic codes on forms to determine if they will cover a treatment. Trans-patients need to be diagnosed to show that medical and psychological treatments professionals administer are ethical. However, when trans-patients are diagnosed as having GID, they run the risk of being denied by insurance companies and labeled as mentally ill. Dr. Susan Morgan proposes a solution to address this problem.

I think if it had a suitable place in the ICD 9 coding. And so that a diagnosis could be placed on it as basically an intersex condition. That's where I think it belongs, as under intersexed conditions. It just happens to be brains that are intersexed, not genitalia that are intersexed. So I think, to me, that's where that belongs. In the ICD 9 coding of intersexuality. I believe it's an intersexed condition and it should not be in the DSM.... Because it's certainly nothing psychological. It's not a psychological condition... Well ICD 9 is the medical diagnosis. And what happens is that in order to get it covered, for anything, it needs to have a place somewhere in the medical jargon.

Some professionals explained that they thought GID belonged in the ICD because it should be viewed as a medical condition requiring a medical response (i.e. surgeries). Having DSM in the ICD would remove the psychological stigma for trans-identified individuals, provide the medical treatments they desire, and perhaps encourage insurance companies to cover medical services related to GID. Including GID in the ICD, even if it were removed from the DSM, would still allow professionals to have the ability to communicate with other professionals, patients, and insurance companies. However, Dr. Morgan suggests that GID and intersex be combined as a medical condition. This is not consistent with the current version of the DSM-IV-TR which states that a patient cannot be diagnosed as GID if they have an intersex condition (576).

DSM Needs to be Empirically Grounded

Whether professionals believe GID should be removed from the next DSM version or not, many find that diagnoses are outdated and do not reflect the current knowledge and understanding of those who medically and psychologically treat trans-people, as Joseph explains.

Well the DSM diagnoses are still pretty far behind. I think this view is understood by professionals in the field... I don't actually think that the general medical or mental health community understands these [related to trans-people]

phenomena... So in general the knowledge of this is way behind where the professional community [WPATH members] is.

While some argue for the removal of GID from the DSM on these grounds, Joseph suggests that GID should remain in the DSM.

The DSM IV was a tremendous step forward from past DSM's which were pretty flimsy in terms of their empirical grounding. DSM IV was better, DSM V will be much better. From the beginning with both DSM IV and V the understanding is that it has to be based on research. A lot of diagnoses were thrown out because there was no research on them to support it. It is not going to be perfect, of course. These things are very difficult to categorize. It is nosology. It is simply trying to find labels to put on clusters with often confusing symptoms. But we need it as a way to do more research to communicate among clinicians. Unfortunately, we need it as a way to get insurance coverage. If I can't put down a DSM diagnosis for something it is not going to get covered, which is unfortunate. So the DSM serves many different functions, but I do believe they have come a long way and they are striving to get it grounded in research. I do not think it is a fair statement to say that it [DSM] is subjective.

According to Joseph, including GID in the DSM makes it easier for doctors and therapists to treat trans-people, to communicate with each other and insurance companies, and conduct research, increasing empirical support for the DSM. Unlike some professionals and many trans-patients who are also members of WPATH, Joseph does not believe that the DSM is a subjective document, void of any empirical support, and therefore does not believe that GID should be removed from the DSM. Joseph warns of the problems that arise when professionals concede to patient demands.

This is a good example of the dilemmas of people [non-professional trans-people] come in with some pretty tense feelings about these things and some conflicting ideas about their interpretation and they can be pretty aggressive about it. Which I think detracts from the science above all and the ability to sort of take a professional approach to these things.

Unlike Joseph, many respondents do not see ‘science’ and trans- patients’ perspectives as mutually exclusive. In fact, many medical and mental health workers do not strictly follow the DSM and SOC but adapt them to fit with their patient needs as Dr. Martin Callahan shows:

Not all my patients fit into GID. Certain percent have no interest in being full time female. They may cross dress. The rest of the time they are happy in their male life. It may be they are worried about their job. Maybe their wife doesn’t want them to be women. It may be that they cannot afford it... I think they have every bit [to] have a right to have surgery.

I will expound more on this point later in this chapter and in chapter 5.

SOC Provides Credibility and Protection

Professionals use the SOC because it helps them make and legitimize decisions with trans-patients. Fellow colleagues and patients see them as ethical because they are using tools accepted by the medical and psychological fields. Providing treatments to trans-people can be a dangerous endeavor as the recognition and treatment of trans-people is rarely accepted or promoted. Even within WPATH, one of the only professional organizations set up to deal with such issues, is at times divided on how to appropriately diagnose and treat trans-patients. Physicians and therapists who do not adhere to acceptable ethical standards fear having their professional license revoked, being sued by patients, or losing the respect of the medical community.

Making decisions is difficult for therapists and doctors because unlike more traditional patients, trans-individuals seek out procedures not usually administered to those of the opposite sex (i.e. estrogen given to males) and unconventional services such as GCS, creating ethical dilemmas. Health care workers struggle with being ethical as

they also want patients to perceive them as helpful rather than as a gatekeeper to services. According to the Hippocratic Oath, a doctor must do no harm. Harm is generally interpreted as applying treatments to body parts which are well-functioning. For example, when a surgeon removes functioning testes, other health providers may see them as unethical because the testes are not diseased and removing them interrupts a patients' ability to reproduce. Hence, deciding to assist patients can be a dangerous choice to make, especially if medical organizations do not formally acknowledge trans-people or the interventions used to currently treat them, as therapist Brett Zelman discusses the problems with giving feminizing hormones to male-bodied people:

So for instance, the issue of giving hormones or not prescribing hormones. The medical people...their licenses were on the line to some extent. This is a very serious issue; this is their livelihood. And particularly when trans was not in the mission statement [of the organization he worked with], it meant that should a doctor prescribe hormones to somebody...and that person for whatever reason sues the doctor, the board would not be likely to support that doctor...which means that the agency's lawyers and malpractice wouldn't necessarily back that doctor.

Without formal support, many professionals refuse to treat trans-people. Even when support does exist the ethical dilemma may still exist as Dr. Alex Boyd clarifies:

Should we be doing this at all? Just because we can technically do something doesn't mean we should do it and I think, now having spent many years caring for transgender individuals in a multidisciplinary way, participating in conference locally and nationally, internationally speaking with health care providers, patients, their families, their spouses it's really transformed my...its been a 180 degree shift and I think that is the purpose of education and its when you are ignorant to a certain topic it is easy to be scared or skeptical but as you learn more and study more and interact and work with people you learn and it is a process and it is not something you can expect.

Ethical pressure at times is alleviated the more a health worker interacts with trans-patients and trans-medical-communities. Treating trans-people, giving hormones, performing GCS is not widely accepted medical practice. Therefore, education about and experience with trans-patients may lift the ethical and moral restraints which keeps others from treating trans-people. However, sometimes patient requests are not enough as Sarah Elan recalls a colleague's experience of halting a surgical procedure once the patient's mother threatened legal action.

That put a lot of pressure on us. You don't want to go forward with removing healthy stuff without a good consensus [support from family].

This example reveals pressure professionals feel to not only meet the needs of the patient, adhere to acceptable standards of ethics, but to also consider how treatment decisions affect those closest to the patient.

A final concern is that many treatments, especially surgeries, are irreversible.

Knowing this places increased pressure on professionals to not concede to patients' desire for treatments. Dr. Boyd explains his struggle with this:

Our goal is not to be gatekeepers but we do take the responsibility of irreversibly altering somebody and from our own ethical perspective we want to make sure that we are doing the appropriate thing so it is not done to make people jump through unnecessary hoops it is there to make sure as best as we can do to do the right thing for that individual.

Dr. Callahan explains this pressure, although he does not himself experience it:

Maybe they [patients] know that if they want to look male again, I can do that but other doctors cannot perhaps reverse their work so [that] they have more control over it. I don't have an insecurity about what I do. Many doctors may think 'what do I do if the person changes their mind?'

Dr. Callahan has less reservation because he can reverse his surgical work⁵. Doctors and therapists are more likely to assist trans-people if the ethical issues are minimized.

Usually these concerns are squashed when there is outside support to treat, either from family or colleagues and when administered services can be reversed.

Due to the ethical dilemmas associated with treating trans-people, many professionals, like Joseph, support SOC guidelines.

One thing we don't need more of which I did a review of is the outcome research of treatment for specifically GRS [gender reassignment surgery]. That research literature is very clear---it works. It helps and more specifically it works better if people follow the steps that have been outlined in the SOC.

Therefore, doctors and therapists use the SOC because doing so benefits patients as Dr.

Boyd reveals:

And you learn this isn't a decision that someone made an hour ago that they were trapped in the wrong body you know and even to this day we follow international guidelines because not in the sense of being a gatekeeper so to speak but we want to make sure that we are appropriately identifying individuals in my mind that would benefit from surgery. It's still a matter of making an accurate diagnosis and formulating an appropriate treatment plan.

The SOC legitimizes treatment decisions especially when mainstream medicine and society find such practices unethical. Therefore, following the SOC reduces the risks associated with doing this work and ultimately protects the professional, as Diane Olsen, a psychologist, explains.

In plastic surgery you are bringing somebody in more into alignment with the cultural ideal and when you go through gender transition you are bringing them out of that. You are bringing them towards a position where they are going to be a discriminated against minority where they could lose their friends and family, jobs and children. So you are actually doing something that could endanger their welfare. Now I can say yeah, if I am a woman and I am leaving as a woman and

⁵ This particular surgeon does not perform GCS.

its going to help me live as a woman then it is sort of a no-brainer but you could look at it and twist it this way and that way. Where you really really get into super high risk and there have been doctors that have served time in prison for doing vaginoplasty and penectomy is because you are messing with people's reproductive rights.

Diane also reveals the dilemma with deciding whether treatments are ethical or not according to the medical "do no harm". One way of dealing with of this pressure is to ensure that clinical encounters with trans-people are equal to that of other patient populations and adheres to professionals' perception of acceptable medical work.

Because plastic surgeons don't just do anything that anyone asks them to, they screen patients to see if they are realistic and if they really can do this thing and they have to have a share sensibility of what is going to look good... And it is very common when people have a vasectomy or an abortion that they have to have counseling first. So this is really a big myth that no one else has an evaluation. A total myth. If you have weight loss surgery you have[a] psychological evaluation. And in most cultures if you remove somebody's penis it is the worst possible thing that could happen. So I don't think it is any small wonder why it would put that doctor at a very high risk of all kinds of things to do that surgery.

The SOC represents a "shared sensibility", a way for professionals to standardize their work, and reduces the level of risk associated with performing surgeries and treatments most societal members find immoral, especially because of the high importance it places on sexual anatomy and reproductive organs. The SOC are professionally-grounded accepted steps which lend support to service providers, especially surgeons performing CGS, so that the decisions they make are viewed as ethical and supported by a body of knowledge. Comparing the SOC to practices commonly found in mainstream medicine establishes support for using the SOC, guarding decisions professionals make from scrutiny by fellow colleagues and patients. Although, none of my respondents had ever

been sued or lost their license or knew anyone who had, many were fearful of such responses as Sarah Elan shares:

I remember one person [female to male trans-identified person] that was having a hysterectomy the next day and her mother said if you operate on my daughter I will sue you and it was cancelled.

Dr. Friedland has similar concerns:

I said every time I do this [administer hormones] you know my license takes a little walk onto the precipice because it is not in the mainstream. If I just put you on hormones do you think any medical board looking at this, they would call me a nut. They could file child abuse charges against me.

Providing service without a formal process or merely at the demand of patients without other forms of support devalues and delegitimizes the profession.

Many equate professionals who do not use the SOC to treat as medically irresponsible, as Dr. Ingersol shares:

A person who had previously been to someone that did not follow SOC and was butchered;---amputated penis which left an unattractive genital area but prevented them from having a clitoris at any point and this although was a past surgery this was done recently and this surgeon did it with no questions asked.

The SOC does not tell surgeons *how* to perform GCS. It only provides guidelines on how one should transition and which steps should be taken in which order. Not following the guidelines of the SOC may cause a surgeon to perform an aesthetically great surgery on the wrong person but would not cause one to botch surgical results. Dr. Ingersol assumes that medical health professionals who do not abide by the expectations set forth in the SOC do not care about trans-patients and cannot and should not provide treatments to them.

Professionals use the SOC as a framework to ‘align’ their treatment decisions to ensure that what they *do* with patients minimally fits the SOC so others will continue to view their decisions as ethical and credible. For example, according to the SOC, aside from diagnosing a patient with GID, professionals should also establish if the patient has any other co-morbid psychiatric conditions prior to providing treatment. Dr. Frank Jolsen shows how SOC specifications force doctors to choose their words carefully when speaking about trans-patients. When I asked Dr. Jolsen about how a patient was emotionally unstable, he corrected my terminology.

I would not say emotionally unstable, because one of the criteria for doing this operation [gender confirmation surgery] is emotional stability. I would say that this person is very demanding, a very demanding, high needs patient.

Admitting emotional instability could indicate other co-morbid issues, suggesting transition-related treatments were inappropriate. Professionals are careful in choosing their words to adapt their decisions to the steps and definitions outlined in the SOC. The SOC statement that a patient should be diagnosed as gender disordered prior to undergoing treatments but that this diagnosis can be revisited over time, protects professionals from being accused of making the wrong decision.

It is not mandatory to use the SOC but it protects me in a court of law and a few people have contacted me to reverse the surgery and they were not mis-diagnosed but maybe they found a certain religion and to undo it is a mistake so I send them back to a therapist. Sometimes they find a partner that is manipulative and that person wants them to fit into their life. I want them to have support so they won’t be lonely or do desperate things.

Dr. Ingersol realizes how important it is to have this support when the patient decided she wanted to reverse her GCS. Rather than interpreting this as a mis-diagnosis on the

professional's part, she explains it as a patient's change in thought based on new information (i.e. religion or a new romantic partner). Although the SOC states that a diagnosis must come before any other step, it also states that diagnoses can also be reconsidered along the way (25). The SOC allows this leeway for professionals so they are not considered unethical in the treatments they provide or applying them to the wrong people. Dr. Ingersol does not frame this situation as a mistake or a mis-diagnosis which I would argue could diminish the credibility of her decision-making and her use of the SOC. Dr. Morgon supports this.

I think a lot of providers use standards of care as kind of their little crutch, or their handicap thing. Like they fall back on it, like it's sort of...like it's a...instead of it being used as a tool to provide good care, they use it as a foundation and if that crumbles, you know, nothing else is really their fault.

While the SOC may help some professionals make treatment decisions it also allows them to escape scrutiny if those decisions prove to be inappropriate.

Re-Working SOC and DSM Guidelines

Many times professionals cannot strictly follow the SOC and DSM guidelines as they can make their job and patient's lives more difficult. Many times therapists and doctors must decide exactly how and which parts of these documents they will use. Therefore, they re-work and re-interpret the DSM and SOC in ways that will benefit both them and their patients.

DSM and Insurance Companies

Professionals' diagnoses are heavily influenced by insurance companies. Currently, patients need to be diagnosed with GID in order to receive transitioning-

related surgeries, especially GCS. Insurance companies, unless there is an unforeseen loophole, rarely cover trans-related procedures. Currently, medical/mental health professionals feel that the only way to appropriately assist trans-patients is through medical, not psychological care. In other words, the correct 'cure' for trans-patients is hormone therapy or surgery rather than therapy⁶. Since the appropriate treatment is medical, insurance companies will not cover psychological treatments. However, they also will not cover medical treatments as they feel these treatments are elective, as Joseph Anderson points out.

Unfortunately, 35 years ago there was this bias against transgender and the medical treatment of those people and the insurance companies latched onto that and said this is a psychological condition and we shouldn't pay for it they say it is elective or cosmetic surgery, that's most common and therefore we are not going to pay for it and that is how they have avoided it.

Therefore, many mental health professionals will diagnose a trans-patient with depression or anxiety disorder to ensure they obtain insurance coverage since diagnosing them as having GID will exclude them from coverage. Once insurance companies are aware that a person is trans-identified, they can also refuse to cover non-trans-related medical or psychological procedures. For example, in previous research where I interviewed trans-identified individuals (Dewey 2006), one male-to-female respondent shared that once her diagnosis of GID was revealed to her insurance company they not only refused to cover her estrogen pills needed to transition to female but they also denied coverage for her

⁶ While therapy is useful and needed for many trans in both dealing with their gender and non-gender issues and to obtain an official diagnosis for medical treatments, the current belief is that therapy should not be used to cure someone of their trans-identity. With the later work of Harry Benjamin, mental health professionals no longer believed that psychoanalysis should be used to change patient thinking but that surgeries could be used to alter the body to match the mind instead.

heart medication. According to her, their reason was that estrogen could cause blood clots and therefore the heart medication was only needed because she was taking medications related to her trans-gender status. Usually it is the patient who is most familiar with their insurance company policies and therefore, will tell the medical/mental health professional how to diagnose for insurance purposes, as Joseph continues.

And the mental health treatment was covered but the diagnosis was not GID but depression... I learned from the beginning that you do not put down that diagnosis...unfortunately for insurance companies it is a red flag and I well two things: one is that there is not good confidentiality of medical records, often employee companies..so a big issue is confidentiality and privacy. Second is that it does become a red flag so suppose they [patient] want to have hormones, surgery down the road, if they have that diagnosis in their chart they have a harder time doing that... Yes, because again, the best way to get the insurance reimbursement is to frame it as a medical condition and not a psychiatric condition...so if you can argue that there was an intersex condition or some hormonal condition if you can make a purely medical argument for it you are more likely to get reimbursement for the surgery... but it actually has to exist, you need the evidence... It varies. I've seen it go both ways but the problem with the GID diagnosis is that once you get that they can keep saying 'well this is a mental disorder' and therefore, they need mental health treatment and not surgery or hormones. It can cut either way. I've had other cases where the person wants me to label them with GID as part of the push for insurance coverage so that really can cut both ways.

Professionals realize that for patients, being diagnosed is a catch-22. Trans-identified people need a diagnosis to receive medical treatment while at the same time the diagnosis will open up future doors for discrimination as insurance companies can deny covering trans and non-trans related surgeries/treatments. Removing GID from the DSM may not be helpful as the diagnosis needs to exist in order for patients to receive services; professionals use diagnoses and codes as a way to communicate with other professionals and insurance companies that their patient needs particular services and coverage.

Natalie Hatfield explains diagnosing as a hoop to jump through rather than anything that guides how she treats her patient.

Well I think, well I have to in terms of people want to use their insurance I have to give them a diagnosis. Now I will not give anybody a diagnosis of Gender Identity Disorder. Most of the time it is not covered by insurance so most of the time they either are [diagnosed as] depressed or anxious. So that way they can use their insurance, I get paid, and they get their treatment... I think it is a political thing. It is a whole other piece and it doesn't inform my treatment or how I interact with somebody or how I think about the person, it is more like a hoop and for instance, the way I deal with it with clients is I will discuss it with them and I'll tell them I will not use GID as your diagnosis and sometimes I will ask do you want to be depressed or anxious? Pick your malady because there is enough overlapping and many transfolks are savvy to this. However, if they [patient] happen to have good insurance and they probably already researched this on their own or they are working with a surgeon that says I have to have a diagnosis that's kind of on record or ready so that I need to code or bill an insurance company for GID then I'll sit down and talk with the client and make sure they understand all that if they are having SRS and if they are one of those few lucky ones who can get it covered so then why get that diagnosis in the system. Now there is a difference between what I write in a letter to a surgeon or like an endocrinologist and what I might bill for. So I need to say in a surgery or hormone letter that this person has gender identity disorder. That doesn't mean that I have coded this way in an insurance claim.

As this professional elucidates, diagnosing has more to do with *who* the professional is communicating; different diagnoses may be submitted to professionals and insurance companies. While some professionals admit to using alternative diagnoses specifically to get patients the assistance they need, other professionals use different diagnoses because they felt they were more accurately described their patients' issues compared to GID as Nicholas Thomas shares:

Well I use the accurate diagnosis. So for this person it was depression and that is the diagnosis I go under...Again I'm going to bill generally for what I am treating them for and generally speaking of all my transgender patients I'm not treating them for their gender dysphoria. That is another thing. I'm treating them for their depression, their ADD or whatever.

Rita Roberts provides a similar point:

Your whole gender identity is in question and that is going to make you anxious so let's do that. Or if the person is depressed and has been depressed for a long time and it is not sort of the incapacitating, not getting out of bed depression then I'll put dysimbia... Yeah, no one is going to if I make an argument that this person is you know, a person who is dealing with gender dysphoria is also dealing with a whole lot and so they are anxious or depressed or having panic attacks or having problems managing anger which definitely fold into gender identity but people are not gender identity disorders, people live lives.

These therapists do not feel that they are treating patients for gender issues but for the effects of having gender issues, such as depression and anxiety. Gender is not the problem and many professionals do not see patients' gender concerns as disorders. Brett explains this common understanding among colleagues:

The DSM doesn't say 'medical cure,' but we all know that if someone strongly experiences themselves as being the other sex in reality, despite what the body is saying; and has a strong desire to become the other sex, and that's been consistent over time; and the person is showing readiness and appropriateness to transition then the only thing that will work is transitioning. You know, that's basic Harry Benjamin.

Medical and mental health professionals who treat trans seem to agree, despite GID being in the DSM, that assisting patients in medically transitioning is the only solution; using the DSM is simply a political game doctors, therapists, and patients must learn to play.

Diagnoses are also driven by what services the professional desires for his patient, what treatments his patients wants, and the likelihood of getting it covered by the patient's insurance. Professionals know that insurance companies rarely cover trans-treatments such as GCS. Professionals also know that insurance companies refuse to cover normally accepted treatments if they know they are being used on a trans-identified

individual, such as hormone therapy. Professionals want patients to receive coverage if possible. This next professional, knowing that her patients insurance would not cover puberty blockers for those diagnosed with GID, diagnosed her patient with a more acceptable medical condition, precocious puberty. A pre-pubescent trans-identified individual may receive puberty blockers in order to delay puberty. Taking this medication will keep the body from developing secondary sex characteristics expected for one's natal sex. For example, if a person assigned female status at birth believes she is male taking puberty blockers will stunt puberty which for a natal female would mean that he would not develop breasts. For a trans-person, having the body of the sex of which you do not feel you are can be psychologically and physically tormenting. Unlike many surgeries, the effects of puberty blockers can be reversed once the patient discontinues use, as Dr. Friedland explains:

I think parents have tried [getting insurance to cover puberty blockers for their transgender child] depending on the diagnoses. Certainly for stuff like precocious puberty it would be accepted...Oh, sure. We'll do it.[Referring to diagnosing someone as having precocious puberty to ensure that insurance covers their medication].

Professionals juggle with diagnoses so that patients can receive the services and financial coverage they desire.

How professionals diagnose can also come out of a discussion between the patient and the doctor. Rita Roberts explains her rationale for diagnosing a patient with anxiety disorder or depression over GID.

Oh, well you know the paperwork I do for insurance companies wants a diagnosis. Generalized anxiety disorder or some low level depression is a legitimate diagnosis and often part of the person who is doing the gender issues is

experiencing. On occasion I will use gender dysphoria but now I don't want to run the risk... Based on self-report from the person in therapy....sometimes people will say 'please don't put dysphoria, don't identify me in any sort of way dealing with this' [transsexualism]. And in general as a therapist is pick the most benign diagnosis anyway because I don't know where that information really goes.

Professionals learn from their patients that diagnosing them with GID can create

discrimination at work or denial of coverage by their insurance companies.

Professionals, such as Dr. Alex Boyd, rely on patient knowledge of their insurance

carriers since experience shows them that companies' response is inconsistent:

They [insurance companies] have no rational basis for how they make decisions. We can have two identical patients with the same policies, submit the same letter of pre-determination and get different responses so I cannot begin to figure that out. It depends. Patients are very educated and they have looked into it. If someone wants us to proceed with it at times we will, some people may not want us to go through insurance, there are a whole host of issues. If someone asks us to proceed to attempt to get coverage we certainly will...In spite of and despite things, things can get out and people have concerns about that.

Dr. Boyd continues:

If we write a letter requesting pre-certification to the insurance company and again it depends on individual plans, a funded plan where the insurance company is a third party administrator but the corporation or whatever determines these benefits and there are any of the usual breaches of confidentiality that can unfortunately occur.

Professionals are most concerned with the patients' well-being. Professionals fill out

insurance forms based on patient direction. However, some professionals do have to

interact with insurance companies and collaborate with each other on behalf of particular

patients. Joseph Anderson explains his experiences:

Well it usually requires getting the physicians involved also. Writing letters, getting the surgeons, the endocrinologist to write letters saying that the argument essentially is that this is a known medical condition for which there is well

document medical treatment so we can point to reams of research that demonstrate the efficacy of gender reassignment surgery. I often say to people that the success rate for that is better than most medical treatment we have, about 80% depending on how you define success. So we essentially argue that this is a medical condition that has biological origins and therefore the appropriate treatment, biological treatments are appropriate.

Professionals struggle to secure treatments for patients. When patients agree that it is appropriate, professionals will attempt to convince insurance companies that the treatments they recommend are needed and should be covered.

Most times, trans-patients are unsuccessful with obtaining insurance coverage for two reasons. For one, insurance companies are set up to make a profit and therefore must reject more claims than they pay out. Trans-related claims seem to be an easy group to exclude. Joseph continues:

But if you ever had to deal with insurance companies you understand that their goal is to provide fewer services. They find excuses to deny services.

In addition to denying services, insurance companies will also employ stalling tactics, as Joseph shows:

Well they didn't respond to me. I just essentially provided the letter to the patient and he put together the argument to the insurance company. It's not resolved. They have kind of been stalling and delaying which is another insurance company tactic, hoping that he'll just go away. So it is not resolved but they are still balking at covering the surgery. The person went and had the surgery which may make it more difficult to get reimbursement.

Secondly, insurance companies can re-write their policies. Even if professionals, such as Joseph, are able to successfully argue with companies to secure coverage, insurance companies have the ability to quickly close the loophole:

Well there was a loophole and in his particular blue cross blue shield policy and so I wrote a letter that it was a medical necessity for this person to have this

surgery and wrote a letter that went back into this persons history that documented their history what they had done for transitioning. Put that together with language from the Harry Benjamin standards of care and then drew conclusions and they paid for it. They have since, this was 3 years ago, they closed the loop hole so that will never happen again... they just re-wrote the policy... They excluded, every insurance company has the right to make exclusions. We are not going to do cosmetic surgery, not that this surgery is cosmetic but it got excluded so we are not covering it, it doesn't matter. Doesn't matter if it is necessary or not we are not covering it.

Professionals' diagnosing and treatment decisions are reflective of more than the existing knowledge found in the DSM and SOC. Their work is also guided by what they believe insurance companies responses will be and what services they hope to secure for their patients. Since many insurance companies refuse to acknowledge the existing trans-related medical research, professionals must use the diagnosis most likely to award the patient coverage.

SOC

While the SOC requires trans-patients to obtain at least one letter confirming GID diagnosis for hormone therapy and reversible surgeries and two letters, at least one from a PhD level therapist, for GCS, professionals may re-work the guidelines for efficiency. The SOC also states that a patient must be diagnosed before beginning to live full time in the opposite gender, also called the real-life experience (RLE). A patient must engage in RLE for at least 3 months prior to receiving hormones and 12 months prior to obtaining GCS. This process also assumes that a patient physically meets with a professional while engaging in this process which can be overlooked to best meet patients' needs, as Dr. Judy Ingersol shares:

I can't remember, some people had a hard time getting a second letter and I talked to docs. I treat people that are not in my area and it is better for me to manage their hormones a couple states away so from a harm reduction [perspective] I would rather treat them then have them go untreated and I will speak to other doctors that they could physically see in their state but I would talk with the doctor about hormones.

Dr. Susan Morgan also explains how she responds when patients have difficulty getting a second letter:

[Patients need] Two letters. Depending on...we have changed. We do break from the standards of care when they've had a prolonged real life experience...it has to be documented in the primary therapist's letter.

Janice, a therapist, shares how the SOC can limit her ability to help younger patients, especially those who desire transformative treatments prior to engaging in the RLE.

The real life experience I guess I am fluid on that too because I work with a lot of young people and a lot of them are in college or in high school. They know they're transgender. Their just not quite ready to come out or they are afraid to come out for safety or because of their jobs or they just started a new job and they need money for college and they're like 'If I come out and start living full-time I'm going to lose my job before I can get money for college.' So often time I will just go ahead, I will write a letter for them so they can go ahead and start hormones and then as we feel its appropriate and as we set up support systems, we set up some type of structure to come out and how to be safe and who to come out to in that whole process and then they can start doing it on their terms, again I don't think I should be the one to get in their face and say you have to start living full-time right now today for the next three months before we start giving you hormones.

Strict, rather than fluid, adherence to the SOC can be counter-productive to what the patients sees as the best transitional path. Dr. Morgan also uses the SOC in ways that best assist patients' needs. She argues that since the SOC was written by people who are not trans-identified then perhaps they do not know what is best in identifying or treating them.

But I looked critically at the standards of care and applying that to the patients I see. I made my own conclusions about it. For example, the standards of care, they even say right at the beginning, that they are designed to allow flexibility. And so they always rely back on the advice of the therapist and the decision of the physician who's treating, whether in surgery or whatever. So I took that kind of as an invitation to apply maybe my own standards that I thought were appropriate.

Although Dr. Morgan is correct that the SOC indicates that these steps are guidelines, the document also clarifies that the standards are *minimal* requirements, allowing room for interpretation which, as Dr. Morgan shows, allows professionals to use the SOC in ways they believe best. Dr. Morgan continues.

So counseling and all the stuff, screening, that I think became part of the outsider's. Because, really, the standards of care were written by outsiders. They were written by well-meaning, well-intentioned persons in the various disciplines, but they were...they definitely weren't...themselves...trans. So they didn't have that ultimate inside to where things were at. So making a person get a second letter when they'd lived for let's say 18 years as a woman and comes in and they're obviously a woman, why does that person need two letters? It just seems ridiculous. Are they authentic? If the first person says yes, that's enough for me. They're authentic by the fact that they've lived this way continuously and it's like, you know, there's not a way in the world that they're ever going to go back. That person doesn't need...because I've seen that sometimes happen, too. Where the person ends up spending so much money, I've heard as much as \$2,000 spent, just getting a second letter.

One of the debates within the WPATH community is who is qualified to speak about trans-issues. Reflecting back to earlier in this chapter, Joseph argued that trans-patients' opinions detract from the science of official documents; however, Dr. Morgan contends that because the SOC are *not* constructed by trans-people then they are not credible or applicable to trans-people. Therefore, she incorporates the "science" with what she learns from trans-patients in the process of her clinical encounters. Similar to Dr. Morgan, many said that they did not feel comfortable being the gatekeeper for their

patients or making them jump through more hoops than needed just because it is suggested in the SOC. Rather, medical and mental health professionals took the lead from their patients on when to transition but structured how that transition unfolded. These are points I will explore in more depth in subsequent chapters.

Conclusion

Professionals use the DSM-IV-TR and SOC to effectively treat their patients and to retain their success as professionals. They use these documents to administer the best care for patients. However, when providers find that their decisions or interactions with patients do not coincide with document specifications, they attempt to fit their decisions back into the existing guidelines and terminology, argue that SOC are meant to be used fluidly, or discredit the document as pathologizing or empirically weak.

Professionals also use the DSM-IV-TR and SOC to legitimize their field and individual treatment decisions. By using these documents, medical and mental health providers ground the unconventional work that they do into a shared, acceptable, body of medical knowledge. When they align treatment decisions with the DSM and SOC they are viewed as ethical by fellow colleagues and patients. Using these documents gives professionals support in treating trans-people and justifies their decisions to outsiders. Professionals feel they need the DSM and SOC in order to communicate with other professionals and conduct research. Therefore, even as they attempt to empirically ground the contents in the DSM and SOC or make them more user-friendly with upcoming versions, the fact that they actively use them legitimizes their importance in treating trans-patients. What becomes even more interesting is to see when professionals

do not use these documents; when decisions reflect cultural meanings of good men and women.

CHAPTER SIX

TYPES OF PATIENTS

Medical and mental health professionals discuss the types of patients they encounter. Respondents' pertinent concerns with patients include compliance, unrealistic demands, especially revolving around time, meeting patients requests, and establishing a trusting relationship. Through their description of difficult, rewarding, successful and unsuccessful patients, they police the sex/gender dichotomy and send messages to trans-patients about what it means to be a 'good' patient and an acceptable man, women and/or transsexual. Additionally, the ways in which they speak about patient types reflect their understanding of what it takes to be a 'good' doctor.

Difficult Patients

Professionals are concerned about managing what they considered difficult patients. Difficult patients challenge professionals' need to provide assistance with performing quality doctoring. Medical and mental health providers expect trans-people to behave in a particular manner aligned with what they believe a good patient should act like. Additionally, they expect that trans-people will act in a way that is consistent with moving from one gender to the other. Patients who do not play along with these expectations force the health care worker to devise new responses to them.

Difficult patients emerge from three main topics: unrealistic expectations, time, and co-morbidity. Professionals find patients who demand transitioning-related services before they feel comfortable providing them as difficult. Physicians and therapists also find trans-patients either expect or need more of their time than other patients. Another aspect of difficult is patients who disregard or do not comprehend surgical and post-surgical complications which care workers feel can affect their ability to make informed decisions, hence placing more liability upon the professional. Additionally, many find that patients who fail to comprehend the realities post-surgery are less likely to be satisfied with the results, thereby requiring more of the health workers time in addressing those problems. A final barrier professionals' face is when patients have underlying mental health and/or medical concerns. Service providers view patients with co-morbidity as non-compliant, unable to make appropriate decisions, and aggressive.

Patient Time Demands

While professionals agree that time is crucial for treating trans-individuals they rarely have the time they believe it takes to appropriately treat trans-patients. The way the health care system is structured does not provide them the opportunity to effectively assist what they feel trans-individuals need. Dr. Nicole Pruitt explains the importance of time.

I think that just in general there are too many time constraints. Most places try to get you to see more and more people in a day and it doesn't give you much time to talk to people. If you do talk to them you end up getting behind. Trans-patients have lots of issues. You can't just blow them off in 12 minutes.

Trans-patients are seen as having many concerns which need to be addressed over time, and in a multiple-disciplinary way. The health care industry is structured in a way that is counter-productive for addressing the various needs professionals' believe trans-people have.

A place of contention between patients and service providers revolves around the issue of time. For many trans-patients, their transition has been unfolding for much of their life. Many deal with gender from a young age so by the time they meet with professionals they are quite sure as to their diagnosis and the steps they want to take in their transition. However, according to the SOC, transitions occur in a process of steps which take a minimum of 12 months. SOC guidelines indicate that a patient must be diagnosed as having GID prior to transitioning. A person must live for at least 3 months in their preferred gender or engage in a comparable period of psychotherapy prior to hormone therapy and live at least 12 months in their chosen gender before undergoing GCS. This time helps professionals to make good decisions, or to at least feel that patients have taken enough time to make their own appropriate decisions, and to reach a level of comfort with providing services which are many times irreversible and viewed as unethical. Professionals need enough time with patients to feel that this person is appropriate for transitioning; thereby reducing their own responsibility if a patient eventually feels they made a rash decision. Some patients, on the other hand, do not want to wait. However, doctors and therapists do not like to simply give patients what they want without employing proper 'doctoring' techniques as supported in existing medical knowledge. Dr. Friedland provides a clear example:

He must be kidding. “You think that you can come in here and I am not even examining you and give you hormones?” I said “that is not the way it works.” It doesn’t work that way for pneumonia. I have to examine you and evaluate and all of that. (Because of what they see on the internet) they thought I was just handing out amphetamines. I’m handing out diazepam. I’m handing out hormones... Doctor feelgood! “There are a lot of steps that you have to go through before we can say you need hormones...get a physical examination and talk about what your file has been and then I can feel comfortable and you can feel comfortable doing this. And then we can trust each other”...I said “look, the buck stops with me. You will not find another doctor. You may find the drugs on the street but you will not find a doctor that will monitor you, prescribe for you and take care of you. I’m it. Tag I’m it.”

Dr. Friedland wants to be seen as a good doctor by applying particular steps and appropriately identifying who and when one is ready for treatments. Giving them without these steps and too quickly, reduces his good doctor role which he desires to a mere drug dealer or “Dr. Feelgood”. Professionals’ need to be ethical, helpful and responsible impacts how they approach and make decisions. Doctors and therapists must balance time as they work with trans-patients. Taking too much time results in the following as Joseph Anderson, a therapist, shares:

Many times they will, if they do not get what they want immediately which is hormones now, surgery now. I want a letter now [or] they will go elsewhere.

Medical and mental health professionals want to assist their patients and prefer not to be the gatekeeper to services, much less force patients to leave their practice. Dr. Eric Friedland speaks to the increased pressure when dealing with trans-children:

Parents [of trans-children] are aggressive once they realize they cannot change their kid. They want transition to happen yesterday.

Professionals realize many patients have been struggling with their gender identity

several years prior to seeking out medical and therapeutic services. Often times they must negotiate the time it takes a patient to transition to both address their comfortability in providing services while not taking so much time that patients leave their practice.

Other professionals, such as Dr. Frank Jolsen, find that trans-patients are difficult because they require a lot of their time. He describes one of his patient's reaction when she could not receive the attention she wanted.

[The patient was] Very unstable emotionally. [The patient was] Very easy to anger. When the patient was in the hospital, [she was] very demanding of the nurses. [she was] Very short-tempered. [She] kind of pissed off all the staff. There's unreasonable demands for time and for attention.

Joseph Anderson provides another example of an aggressive patient while transitioning on the job. Similar to wanting services in a timely manner, many professionals find that some become enraged when they are not accepted by others post-transition.

The transition on the job. She was one of these people that were more confrontational. Again we talked about this and tried to come up with a plan and she really sort of pushed it on her co-workers in an overly aggressive way and when they didn't respond exactly the way she wanted to she would get angry at them. Eventually, well she did make the transition on the job they found an excuse shortly thereafter to fire her. So again I believe that is only because the attitude she took towards them and transition.

Time not only gives medical and health care workers confidence in the decisions they make, it also allows family, friends, and co-workers to become more comfortable with a patients' transition. Professionals find that when patients have unrealistic demands of time, especially if it is coupled with hostile behavior, it not only makes their job cumbersome but usually has detrimental effects on how successful patients will be with their transition.

Despite the pressure from patients, physicians and therapists consider time an important factor as time ensures making an appropriate diagnosis, developing an effective treatment plan, and ensuring that they are making the right decision. Medical/mental health professionals believe that a sufficient amount of time is needed for trans-people to work through the process of transition and to make the best decisions. In addition, professionals experience pressure from their employer who expects them to see patients in less time than is needed to assist trans-patients.

Patient Unrealistic Expectations

Professionals have a difficult time treating trans-patients who have unrealistic medical and social expectations. Many trans-patients expect surgical results to look flawless, come without complications, and solve all their gender and social concerns. Patients who undergo surgery may experience bleeding, infection, and a longer recovery process than they thought. Additionally, they may experience functional and aesthetic post-operative results they did not anticipate. Patients can also have unrealistic expectations about what surgeries, especially GCS, will do for their personal life. Many feel that their gender concerns will melt away, that having GCS will make them feel 'complete'. Additionally, some believe that having feminization surgeries and/or GCS will make them indecipherable from genetic females and hence, they will be able to blend and live their life without any social complications.

Unrealistic surgical expectations

Professionals find that unrealistic patients are tough to treat. Usually they will be unhappy with the professional's surgical work and will require extensive follow-up attention, which will require more of the physicians' time. Dr. Jolsen explains.

I thought they had perhaps some unrealistic expectations. They were very demanding. They were convinced that this surgery was coming to them and the state was going to pay it. And people who have that entitlement and mentality tend to be very difficult.

Trans-patients who demand quick medical attention and access to all treatments pose a problem for providers. Doctors do not feel comfortable and rarely administer transition-related treatments just because a patient wants them. Presently, the process by which one is allowed to have surgery includes clear steps beginning with a diagnosis of GID by a therapist through an established relationship. Once a therapist and a doctor provide a letter indicating one is appropriate for surgery to a patient's surgeon, it is then up to the surgeon to decide if they will perform the surgery. This process allows professionals to feel comfortable in their decision making because delaying services allows doctors the time to better prepare patients for treatments and feel more confident in their decisions.

Many plastic surgeons and mental health providers take time to inform patients of the reality of plastic surgery and GCS. They feel that trans-individuals are really unaware of medical problems that could arise as they are mostly focused on the end results. It is the job of the professional to bring patient expectations and desires in alignment with what is scientifically feasible. Dr. Judy Ingersol explains what many patients expect from their surgeries.

They bring in a picture of a vagina from penthouse and I said I'm not as good as mother nature. If they have unrealistic expectations, I show them visuals of my surgery when it is healed and through healing process, and complications so they can see this. I feel they don't listen to me during this but only think about the end result. I let them repeat it to me so they get it.

Patients have these expectations because some surgeons, especially those who I saw present at the annual Be-All used both natal females and famous women as examples of their surgical work. Many therapists and doctors spend considerable time educating patients on what they can realistically expect from transition-related services. While Dr. Ingersol works with patients to ensure they comprehend the realities of surgery, Dr. Callahan will recommend they see another surgeon.

I will have them send me pictures of them and then send back at no charge a consultation based on those photographs. What is not uncommon is that they will tell me they want to be beautiful. I tell them I cannot guarantee it. If beauty is a must, then you must go to someone else. At least they go ahead with the surgery knowing I can't make them beautiful. They realize it is more important to be female than not.

When professionals realize that patients' expectations cannot be met, many refuse to treat, like Dr. Jolsen.

I've turned people down because I don't like them, and I've just said, "I don't think I can help you. I think that you have more expectations than I can deliver surgically. I don't think I can do the job that you need done." And I've done that once or twice in my career, not more than that. And it basically comes down to me thinking that they have unrealistic expectations and I am not able to help them shape their expectations so expectation meets reality. If their expectations run unrealistic when we start, my hope is that through conversation and consultation I can bring them around to a more realistic expectation. When I am unable to do that, I tell them, "I can't help you. I don't have the skills to meet your needs. So I'm not the doctor for you, I'm sorry."

Most professionals do not want to perform surgery on someone whom they cannot satisfy. Either refusing to treat patients or ensuring that patient expectations are

consistent with what the professional can actually provide are two ways they alleviate this problem.

Some professionals explain they are unable to meet patients' physical expectations because surgically there is only so much that can be accomplished. Surgeons, such as Dr. Callahan, give many explanations for why they cannot meet patients' surgical expectations.

It's very difficult to do certain things, augmenting the human face/skull with your own bone—like the body knows what it wants to look like.

Dr. Callahan explains how biology many times can override his surgical talent. At another point, he continues.

Sometimes it's a person who is just plain ugly and it happens. They are not attractive. Their face is so masculine that you wonder how [sic] are you going to make it feminine. This person is overdemanding. Their demands for looking beautiful. "I can't stand pain." I can't guarantee beauty but I can make you. Person told me "I don't want to be female unless you can make me beautiful." I think it is a very naïve comment. I don't believe I ever had an individual who did not have surgery after I told them [that he could not make them beautiful].

Dr. Callahan, similar to other surgeons acknowledges he can surgically do a lot to physically alter patients but that there is only so much that can be accomplished.

Professionals, when they can, attempt to educate patients about what is possible. They feel more comfortable providing treatments when patients come to terms with the actual results.

Unrealistic social expectations

Patients also have unrealistic social expectations. Often inappropriately, patients assume that post-surgery, their social life will dramatically improve. Many believe

having surgery will not only make them a beautiful woman but others will accept them and therefore they will be successful in finding a romantic partner. Despite educating their patients on various social realities post-surgery, they still find that many trans-people are struggling in their personal life. Joseph Anderson reveals this point.

I mentioned [sic] is I think she had unrealistic fantasies that she would be an attractive woman and straight men would pursue her and she would get married and live in a house with a white picket fence and that didn't happen so she was disappointed.

Joseph continues on this common theme.

Problems in relationships. [Sic] As I say and as I tell people this is the hard part when it comes to transition. Finding and maintaining stable emotional and sexual relationships. For these folks it is simply harder for them to find people that may be interested in them. They look different. They don't have the original genital equipment so sexual problems that occur.

Patients' dissatisfaction with how they physically look, how others perceive them, and their inability to find and maintain ongoing relationships can be a continual challenge for both patient and professional. Joseph elaborates as he speaks about one particular patient.

The dilemma was I think she had from the beginning some unrealistic explanations as to what was going to change post-transition. She had problems with depression and alcohol she was very concerned about relationships post-transition but she imagined that post-transition she would be able to find a straight man interested in her as a woman and settle down. I think she became more stable. We treated the depression and substance abuse ahead of time and after transition she really experienced the let down. It wasn't going to be as easy and despite the therapy and the warnings about this as we obviously addressed these issues over and over and over again in terms of realistic and unrealistic expectations she was disappointed. And she went through another depression and came back fortunately and we treated her for depression, just for that. But I don't think, well I think she kind of waxes and wanes. She still struggled with unfulfilled expectations of the transition.

Professionals are all too aware of the problems trans-people will face with societal rejection. They have to deal with the aftermath of unhappy and difficult patients. Therefore, medical and mental health professionals consider the problems trans-people may face after surgery to help them decide if patients are appropriate surgical candidates.

Patient Co-morbidity

Professionals find it arduous to work with patients who have multiple mental health or medical issues because they need extra attention and direction, which takes time. Co-morbid patients, at times, are also less able to make transitioning decisions and therefore put increased liability on professionals who are already engaging in what some professionals view as unethical work. The importance health care workers place on gender as the problem or other medical and mental health concerns differs and is indicative of how they approach their patients. Diane Olsen, a mental health worker, shares her experience.

Because it was very unusual and it is very unusual and they have a very unique, there is nothing typical about them. They have a very unique experience with gender and they sort of have some mental illness which makes the way they look at the world is very different than the way other people look at the world. Their interpretation of reality and events is different than everyone else's and this makes life difficult for them.

Nicholas, also a therapist, speaks on gender as well.

What I emphasize, with me, is that gender is a sidebar. It's just this interesting other aspect about them but it is not why they are here to see me. They are here to see me for all these other problems.

While Diane believes that gender is a part of patients' concerns Nicholas finds gender is simply an addition to other more pertinent problems. Dr. Jonathon Walters also recognizes that he first must address co-morbidity, rather than gender.

You know difficult to me has nothing to do with their transgender qualities. It has to do with what infection [sic] am I treating. So the most difficult ones are people who are still taking hormone replacement, are changing sex, get too sick to take their medicine because then you are dealing with a whole bunch of issues and that becomes more complex. So you are dealing with how sick they are, you are dealing with the fact that they are withdrawing from their hormones and a whole bunch of changes are going to happen because of that. You get somebody who comes in and they get put on a ventilator and they are on an anti-depressant. They are on estrogens. They may be taking five different HIV medications. They usually have some sort of in my experience a lot are on anti-depressants and you put them on a ventilator they can't eat you have to stop their anti-depressant, you stop their hormones. When they wake up they are going to be very depressed. And in addition to being depressed they are put back into a different body then what they came out of in addition to having trouble breathing and being really sick. That is difficult because then the psychological aspects of where are you how are you how far back are you in the process of where ever you wanted to get to. Those are the difficult patients.

Dr. Walters explains the various physical and psychological concerns he has for co-morbid patients. These needs take precedence over transitioning-related treatments such as hormones. Female hormones, such as estrogen, not only feminize the male body but also affect the brain. Previous research (Dewey 2006) shows that estrogen made them less aggressive and less sexually charged. Removing a transitioning trans-identified female from estrogen not only causes reversal of the changes she has come to enjoy but can create a depressive state physiologically and mentally. Choosing to put a patient on hormones can be as difficult a decision as taking someone off. Sarah Elan explains.

Estrogens are not safe. They have a negative aspect of them—heart attacks, [high] blood pressure.

Dr. Walters found that while gender was not a concern with treating patients, it did pose problems for others.

The gender issues, if I remember correctly were more sort of a pain in the ass. Like where do you put them, what kind of room what kind of bathroom, what do we do with this. How [sic] are the nurses behave to the person that sort of, there were sort of more logistical things.

Co-morbid trans-patients introduce many issues and concerns impacting how providers approach and treat them.

Professionals make decisions about whether a patient is prepared for transition-related treatments based on their medical and psychological health. Whether doctors are prescribing hormones or writing a letter for GCS, they must judge patients appropriateness to continue the process. Sarah Elan, a therapist, explains why she will not recommend GCS for this patient.

She is androgynous, balding, no effort to change hairstyle to look feminine, fingernails dirty, has ringing in ears, history of back trauma. She is on disability and I just don't think, I won't push her for surgery. She is disabled, pathological pathetic looking person. I am no gorgeous girl but if you give no effort to be feminine are you doing the right thing? And if you are drinking or smoking, estrogen is not good for this. [It can cause] blood clots. It could kill you. I am not sure if I will get this person there[fully transition]...character disorders and never will make it. No motivation and many medical issues. She is not able to save the money, \$20,000 to have the procedure. I have not confronted her about not being feminine but I do give her hormones, small doses to be supported but she bothers me...borderline personality...she's a mess but making some strides. They took inadequate personality out of DSM in III and they should have kept it. There are people that are just not going to make it...they are on the fringe and distractors of our society.

Many trans-identified people are not accepted by society; they can be harassed and discriminated against. So when trans-people fail to give effort to how they present themselves physically, then some professionals view them as less likely to succeed as

their chosen gender. When one is merely a ‘distractor’ of our society, then professionals have to contemplate whether this type of a patient is serious or prepared for the difficult transitioning process that lies ahead.

Diane Olsen, a mental health provider, shows how a patients’ medical and psychological makeup became red flags.

In terms in the way they were [sic] function and they were thinking of going through this transition and they had vehement hatred, hatred of men that was like, like it was just huge, hating all men and anything male in itself. That was worrisome because that is not the norm in some. When you come from a place with that kind of hatred and fear and go through transition often it isn’t satisfying because the rage doesn’t go away.

Diane explains that patients’ mental health should not be overlooked because often times issues do not disintegrate after transitioning.

Some professionals feel that co-morbidity may delay the transitioning process but does not necessarily disqualify a patient from receiving services. As long as patients have the ability to make decisions and are physically healthy, Dr. Ingersol believes they are appropriate candidates.

A patient that has a co-morbid szichophrenia, they require a lot of time for me. This person was in and out of prison and really got no help with hormones, no money, no support systems, really bad at following direction, but good candidate for surgery from a health perspective. This person lived as woman for many years and had successfully adjusted and didn’t want to exclude them just because they have szichophrenia. This patient was good but no money and very difficult. There are people that are functioning and if someone is delusional and cannot make decisions but many can and it is not my call and I am very fortunate that I have 5 therapists within a few miles that can make that decision.

Dr. Ingersol stresses that mental health concerns should not keep someone from obtaining medical services, as long as they can make appropriate choices during the process. Dr.

Ingersol also shows support for the need for professional collaboration to substantiate particular decisions. Although she has her own perspective about who is appropriate for surgeries, she is glad that there are many therapists in her area that she can call on to actually make those decisions.

Sometimes co-morbid patients make professionals' work difficult to accomplish.

Sarah Elan suggests that co-morbidity actually results from non-compliance.

Many of our patients don't follow directions. We need more research in morbidity. If people die and what is the cause? Usually it is because they don't take care of themselves or follow our directions. It's a moral issue.

Dr. Alex Boyd explains how co-morbid patients present trying situations.

Hostile, extremely hostile, a lot of anger. Challenges the professional to the nth degree. Swear at the professional. Called me and I had kind of known about this person through the grapevine. Psychologists warned me don't see this patient.

Since the trans-medical community is small, it is quite likely that medical and mental health workers will provide information to each other regarding particularly difficult patients.

Many times professionals decide how to treat patients based on how difficult they view them. Some health providers suggested that rather than not treating difficult patients, they could make patients less challenging by addressing patients' gender concerns. Additionally some argued that by initially treating patients' gender concerns could diminish other medical and mental health problems, as Dr. Boyd reveals.

I'm not telling you how to practice psychiatry but treating the gender dysphoria may help this patient become more compliant and would improve this patient's prognosis. He basically told me to F [fuck] off in a nice way. "Oh, no, I'm not doing that until this patient complies". It's an arrogant control issue. They

[colleagues] don't understand that if you begin hormones you may alleviate some of the other problems.

He continues.

...drinking issues, drugging issues, sexing issues. All kinds of aberrant behavior that is a result of not dealing with the gender issues and we see that all the time.

Addressing patients' gender can reduce other medical and mental health problems which may or may not be caused by their dealing with their cross-gendered feelings. Nicholas, a therapist, recommended to his patient, against the wishes of his clients' spouse, to begin feminizing hormones as they would effectively deal with his severe depressive state.

Responses to Difficult Patients

How medical and mental health professionals' respond to difficult patients reflects what they believe their role should entail when working with trans-patients and how they feel the doctor-patient relationship should develop. Overall, health providers agree that they need to educate trans-people and display patience as they see them through the transitioning process. Professionals such as Dr. Jolsen, explains how he shows patience.

To be very careful. To chose my words well. To dial up my patience so that I can be doubly patient. And to be very thorough in my description of risks and complications.

Medical and mental health professionals, despite unrealistic patients, believe that it is up to them to educate patients about surgical plans. In this way, providers remain in control of their work and can best guarantee that both they and their patients will be satisfied post-treatment. Dr. Jolsen speaks about a very difficult patient and how he responded.

Just very rigid in their desires for the way things were going to be done, the order in which things were going to be done. Trying to negotiate the way things were going to be done. In a way [that he could not make them beautiful] that was more than the usual. The size of the penis, the timing for the testicular implant, the number of stages required, how long the catheter would have to be in, where I was going to get the skin graft from. Every single detail of the patient's care plan was something that demanded a negotiation from the patient. And that's not the usual... Very patiently, as the best I can describe. There's nothing else I could do. The guy had a real need for the surgery. He was a candidate judged by his psychiatrist to be reasonable. And it was my job to get him through. And difficult patients, in my experience, just require a lot more time.

Professional collaboration is useful in dealing with tough patients because collegial support increases comfortability when making decisions with patients. Despite the fact that this patient is challenging, Dr. Jolsen felt that it was his job to 'see him through' since the patient was viewed by his psychiatrist to be 'reasonable' candidate for GCS. Dr. Jolsen also needs time to work with this patient since he is more demanding than others in how his surgical transition should unfold. Dr. Jolsen describes his work with this patient as a negotiation, using time to his advantage and the psychologist's diagnosis as the green light to provide services to this patient. Most professionals feel that it is the doctors' job to get patients to understand issues related to surgery and post-surgery especially since there is no other way for patients to obtain this information. Dr. Jolsen continues to explain why educating trans-people is important.

Because they [patients] are an unsophisticated consumer. Medicine consumers in this country generally start out being relatively unsophisticated. The amount of knowledge that goes into creating [sic]. The amount of knowledge that is required for a surgical plan, especially something pretty complex, a complexity like gender reassignment would require, is not insignificant. And very few people can acquire that knowledge until they meet with someone who has it who can lay it out for them the manner that it can be best received. I've been doing this for twenty years. I know what the issues are. I know how to create a surgical plan. The patient just wants a penis, "I just want a penis. I've seen pictures in books.

I've been on the Internet." They come in with half information. They come in with things that they glean from non-professional sources. It's almost like a little bit of knowledge is dangerous. And then it's my job to give the complete and total education. That's my job, that's what I have to do.

Dr. Jolsen, like many of his colleagues, believes it is their role to educate the patient about treatment and surgical expectations. Dr. Jolsen argues that only professionals like him have the knowledge and the ability to convey it to patients in a way they will comprehend. He continues to explain how he gives advice to colleagues.

When the patient went back home across the country, I was getting calls from his doctors. They were complaining to me about the same things the nurses were complaining about – this guy is difficult, unrealistic, demanding. And I gave the same advice to them that I'm responding to you with my answers. "Be patient. Be calm. Tell him this is how it is. Try to keep an open mind so you don't throw him out of your office." Because there was a tremendous desire to get rid of this patient. This is not a pleasant person. And I just basically committed myself to getting them through it as easy I could with as little of my hyde on the line as possible. I was very happy to send this patient home to another doctor for minor things after that.

Similar to Dr. Jolsen's previous comment, getting patients through the process is a common interest for health providers as Diane Olsen, a therapist, also explains.

I was supportive. They were a mess in everyway and I was just mostly listening and supportive and I was very concerned too because they were so disturbed.

Dr. Nicole Pruitt through her own transition realized the importance of health care workers to stick by their patients.

You have to only tell one person at a time and then she tried to slow me down so that the one of the last things I did was to tell work rather than the first thing. And I didn't listen to her and I got myself into trouble. There was a lot of things I did and got myself into trouble and she tried to see those things coming and I ignored them. She hung in there with me and I have a lot of respect for her and I do the same thing with my patients now. They don't always listen to me but I don't hold it against them. Things tend to work out with time.

Aside from taking time to help patients through the process, a professional must also not take offense when patients do not follow their advice. Therefore, it is this experience that shapes her understanding of both her role as the doctor and the resistance she may receive from patients. Once professionals find that patients are appropriate for transitioning services, usually established by colleague collaboration, they firmly believe that they must get a patient successfully through the process from one gender to the other. To do this they must educate and negotiate the time required to provide the necessary services. Since the professionals' idea of the particular steps and their order may not match up with what the patient wants, doctors and therapists must display patience and understanding.

Rewarding Patients

Despite all the difficulties experienced with trans-patients, professionals do indicate that trans-patients are some of the most rewarding patients. Physicians and therapists illustrate that the two main reasons trans-patients are so rewarding is because they make them feel good both professionally and personally.

Making Professionals Feel Good

Perhaps because there are not many professionals willing to treat trans-people or because transitioning services are not freely provided, service providers generally feel that patients show gratitude and respect when they treat them. Health care workers also interpret patient compliance as a form of respect, making them feel good about treating trans-individuals. Dr. Friedland explains why trans-patients, unlike other patients, are the most rewarding to treat.

One of the reasons why I think surgeons like working with these patients is because this group is very compliant. And you know physicians love compliance. The physician gets a lot of respect unlike what's happening to us right now under managed care. There is a real gratitude on the part of the patient to the physician. The physicians really feel that they are helping this patient so it is a mutual feeling of respect and gratification of both. Which is novel in 2008 because it is a throwback to the 50s and 60s.

Dr. Callahan has a similar experience.

When I took care of the children [he used to perform surgeries on children with various malformations], the kids hated me, because I was stealing their Christmas vacations with painful surgeries but their parents loved me. But now patients [trans-patients] love me.

Professionals who can improve their patients' lives gain a sense of satisfaction with their work. Professionals feel appreciated when their patients reach their goal, especially when they have done so by following the professional's instruction. Dr. Susan Morgan further illuminates this point.

Their parents sent them to shock therapy and Boy Scouts, and camps and things always trying to suppress their female side, or whatever. And then the person is so distraught, you know, abandoned, they've tried suicide. And then you bring them all the way. Then they come finally to the point where they've gained enough money to have surgery and then you see them months later and their lives are completely turned around. They are happy. They're employed. They have intimacy. That would be an ideal situation where they have everything, but that happens and that is very gratifying.

Dr. Jolsen shares a similar situation.

One is a fellow who grew up, [and] was raised as a girl. [He] had some indistinct genitalia when he was born [and] was raised as a girl. Until high school [he] went through puberty and became a six foot three guy with a beard. Had like 25 different surgeries trying to make male genitalia. Nothing worked, came to me at the age of 56 as a wealthy dairy farmer from up-state New York who had a girlfriend in Los Angeles and he was just ready to put this behind him, and get a penis, and move on. And I made a beautiful penis that had sensation, that he could pee through, that he could use for sex and his life was completely just...fixed by this. Very rewarding, very easy, quick surgery.

For health providers to know that they had a direct hand in moving a patient through a process from one gender to another is extremely rewarding. Many trans-patients are elated that someone believes they have real gender concerns and is willing to work through their transition with them. Additionally, professionals who give patients what they want, especially when they have perhaps been denied by other therapists and practitioners over the years, are not only treated well by patients but are more likely to receive compliance from patients, therefore making their work easier and more rewarding.

Making Professionals' Work Easier

Professionals also find trans-patients to be rewarding when they make their job easier. Many times patients are well-prepared and knowledgeable about their gender concerns and the transitioning process. Dr. Boyd shares the importance of patient preparedness.

There is no question that in terms of being prepared for surgery, transgender community is the most prepared surgery. They have been through years of issues, most well-read as you put it if you lipo or breast implants or lip you basically do physical exam, basic history, discuss the procedure and in general if it is appropriate and you want to proceed and I'm the right doctor for you we go forward. There is no question that the transgender person has been through more know more and more familiar with it [gender and transitioning] than any other patient we take care of.

Dr. Boyd continues.

I wouldn't say more comfortable but it is more clearly they are familiar with the procedures and routines. I mean they have lived this for years as opposed to any other procedures we perform.

Trans-patients are aware of the process and what is expected from the doctor-patient relationship and are therefore, easier to work with. Unlike patients who perhaps are recently diagnosed with something, trans-patients, because they have been dealing with their gender concerns usually for many years, arrive at the medical encounter with a lot of knowledge about themselves and the path they would like to take. This reduces the amount to time and effort professionals have to spend with trans-patients.

A rewarding patient is also one who does not rush the process but willingly moves at a pace the professional initiates. Joseph Anderson's account shows the importance of time and progress.

He followed the SOC, had an evaluation, I mean I've worked with this person for 5-6 years before they had the surgery and worked with him probably a year or 2, 2 years before he even started hormones and made the transition. So he really did it in a slow, careful way,[sic] having the therapy. When it came time to transition he did a terrific job. He went to his employer, explained the situation, and gave him material [information about transsexuals]. They picked a transition time and went so far as they brought me in as a consultant and they didn't know it that I was this person's therapist but they brought me in as a consultant to educate the other employees about transgender experiences in preparation for the transition. So, it went beautifully. No complaints, no problems. He made the transition and he's been there ever since.

Professionals may desire patients who move slowly through the process but they are not keen on patients who do not move at all. A rewarding patient is one who seems to follow the acceptable paths of moving towards surgery and not being in 'limbo' as Kathy Grayson reveals.

Well probably the man who I described earlier who had transitioned, felt good about the transition, felt good about the decisions he had made and now is working on the kinds of issues that people work out. In other words "how do I form a love relationship?" He had kind of, through the process, had felt good about it. Feeling comfortable about [sic] himself.

Kathy Grayson continues about another patient.

Just the fact that he came in with certain issues, engaged in the process, working in therapy, really trying to understand himself, feel better, and make changes and in other words, he engaged in a process that had movement and he obtained some of the goals he had set out to obtain.

Similar to surgeons who want to work with patients they can please because they have realistic expectations, therapists desire to work with patients who are willing participants in the therapeutic process. Success for therapists is about ‘working’ towards something in therapy, that there is ‘movement’.

Some also enjoyed treating trans-people because they found them to be interesting. Dr. Callahan excitedly shares why he believes trans-people make great patients.

One aspect is I enjoy the surgery and I really enjoy my patients. They are more successful and can afford me and whatever reason it is I have very interesting patients. Three have won the nobel prize. Forty-fifty[sic] lawyers or greater number of doctors, many in the computer world. It’s a nice place for TG people, pilots, professors, very interesting. And I enjoy and became friends with some of them.

Trans-people and the services they desire are not mainstream in the medical community. Treating them, for many, is exciting work. Additionally, those who can afford surgeries tend to come from higher socio-economic backgrounds, have ‘interesting’ occupations, and make better networks.

(Un) Successful Patients

Professionals’ description of successful and unsuccessful patients guides the way they make medical decisions and establishes particular standards about masculinity and

femininity. Their accounts about success also solidify what it means to be a ‘real’ transsexual and a ‘good’ patient. These standards further impact professionals’ understanding and use of medical knowledge and produce how patients approach the medical encounter. Professionals’ suggest triumphant patients are those who invest in being either a male or female and avoid being in limbo. This usually requires that patients engage in the medical and therapeutic process. They also measure success by how well patients function, both socially and physically.

Engaging in the Process

Professionals gauge how successful a patient will be by how engaged they are in medical and therapeutic processes. Choosing a doctor is the beginning of that process as Dr. Jolsen explains.

The patient came to me not because of who I am as a doctor. The patient came to me because I happen to do this work and I participate with the Medicaid program. So this patient wasn’t necessarily choosing me because they researched me throughout the world and decided I was the best one. And that sets up a very different patient-doctor relationship than when the patient comes in and chooses you for the doctor that you are. My response is that you have to be very careful with these people because I have to build a doctor-patient relationship from scratch, as opposed to building one from a positive place. A patient that researches me and comes to me because of who I am, not because I’m on their plan, has pre-selected me as someone they want, someone they like. Someone who comes to me because I’m on their insurance plan, they don’t necessarily know me or like me yet. So I have to work very hard to get them to know me and like me so that I have the proper partnership. [Transitioning requires] A lot of time and a lot of visits.

Success is about patients choosing their doctor because they *want* the relationship rather than just simply because they were referred. Dr. Jolsen explains the importance of building a doctor-patient relationship from such a desired foundation. When a medical

relationship does not form under these conditions, it creates more work for the practitioner. Dr. Jolsen ends his thoughts on the importance of time to the medical relationship which Rita Roberts, a therapist, also mentions.

I saw this person from a distance and I thought wow that is a vivacious kind of person and she came down the stairs and it was my former patient and she gave me a big hug and things were fine and things had stayed not so much of the magic of psychotherapy but because she and I had a very good working relationship and it was over a lot of years. But this person was very persistent just very very persistent and just followed through and was a very engaging sincere verbal person.

How comfortable professionals feel with their patients and how much patients adhere to the process doctors and therapists expect makes for a good doctor-patient relationship and successful outcomes for the patient.

Health care workers view positive outcomes as those where patients transition from one gender to the other rather than remain in a state of limbo. Joseph Anderson supports this perspective.

So he is someone who started taking hormones and liked that, grew his hair long and kind of presents as androgynous. Which in his profession can create problems sometimes but sort of ignores them. And spent some time in the early phase trying on the female role. He was on hormones for a while and the next step was the real life test. And he would go out and spend time on the weekends dressed as female. You know did his makeup and got the head shots, you know the glamour shots that they typically do as themselves female. But he gave that up after a while. And kind of settled into this kind of limbo state of taking hormones wearing bra, shaving, having beard removal, had electrolysis. Spent years and lot of dollars having electrolysis but hasn't moved in either direction so she has not, or he has not fully transitioned as female so he lives as male and more to the point continues to be unhappy. So this has not been a successful resolution.

When patients do not follow the traditional process of therapy, they are seen as one who 'dabbles' and therefore is not serious about their gender-identification. The measure for

success is that one should make a decision on transitioning or not, surgery or not. Kathy Grayson describes one such patient.

Genetic male but who periodically over the years had well he always feels to some extent a more feminine male. Sometimes he feels like he really is a woman and would like to transition into more of being a woman. Sometimes he talks about pursuing it medically in terms of hormones therapy, looking at surgery but hasn't gotten that far but has from time to time varying degrees of cross-dressing, body hair removal, makeup, hair cuts so he sort of plays with it. He dabbles.

Patients who are unsure of when or how to transition are viewed as merely 'playing' which is seen as a trait of a cross-dresser rather than a transsexual (Dewey 2006); according to professionals, only transsexuals should be allowed to transition. Therapists find that patients unable to commit to therapy are confused, as Kathy Grayson iterates.

Well difficult because he has real trouble committing to therapy in other words, he engages for a while and then disappears. Because he in some ways he doesn't progress. He is always sort of back at square one. I think he would get out of this sort of limbo state. And that he would define, sort of become more comfortable with his own identity. Be clearer about what that is and he would be able to feel more comfortable talking more honestly with people close to him, for instance his wife. I think she remains in this limbo state with him. She at least the last time I saw him said that she had sought out a therapist for herself to try, in other words, so she was coming home and wanting to talk to him more openly about what is going on but it is all very threatening. And I guess so that is what progress, that is why it seems like a difficult case and there is little progress because there is a lot of angst and suffering. But he doesn't seem to make changes one way or the other.

Patients seen as most likely to adjust post-transition are those who enter into a meaningful relationship with medical and therapeutic professionals and follow the process expected by health providers. Professionals' accounts reflect the importance of patient adherence to the dichotomous gender system as well. How they engage with

patients sends the message to trans-people that, despite some variations in treatment, the overall goal is to progress from one gender to the other.

Function

Another aspect by which medical and mental health workers judge how well patients will succeed after undergoing GCS is how well they function socially and physically as their new gender. Professionals see social factors as impeding success prior to transitioning and as a measure by which one is successful after transitioning. Trans-patients whose new vagina or penis functions as expected for their new gender contributes to how fruitful they will be in their social relationships. Respondents' descriptions of successful and unsuccessful patients solidify the heteronormative order about how bodies should look and behave.

Socially functional

Part of trans-patients ability to prosper as they transition or in their chosen gender relies on their level of social support and acceptability as Dr. Frank Jolsen reveals:

Not everybody is that successful, and it does not always necessarily have to do with surgery, sometimes they're just not successful as people. Sometimes their circumstances don't allow them to be that successful. Most of these people are pursuing this goal because they are very upset in life. They're not whole. They're not balanced. They're not stable. They have a tremendous distraction which is the thought that they are trapped in the wrong body and if you grow up with that you may be somewhat dysfunctional because of that stress. Not everybody has a loving mommy and daddy who see them through it and take care of them. Not everybody has a stable partner and understands that after being married for five years Joe wants to be Jane. Not everybody is surrounded by a world that supports them in their transition. And most of them are not supported by a world that supports them when they are pre-transition, when they're unhappy.

Dr. Jolsen attributes patients' problems to their gender concerns, mostly because they lack support, sometimes even before they decide to transition or undergo surgery.

Professionals understand how important others are in patients' ability to succeed, as Judy Ingersol stresses.

Starts off healthy, is young, and maybe not. Has a support system but involved in divorce, custody with kids. Those [sic] that remain married because they have the support of their spouse, financially ok, and realistic expectations.

In addition to family assistance, Judy also mentions that being financially stable and having realistic expectations are a part of the formula for success. This goes back to how important it is for physicians and therapists in educating patients about treatments.

Finally, professionals measure how well patients are doing if they are engaging in acceptable social activities for their gender. Dr. Jolsen elaborates.

I have another patient who I met when she was 16. I thought she was a natural female. She was a male to female. When she turned 18 she came to me for surgery, male to female surgery. I saw her again about three weeks ago at the age of 23, had signed for a modeling job in Los Angeles, a very lucrative modeling career, and she's getting married, has a modeling career, and is perfectly female in every way. No complications, a beautiful thing.

This account reflects that being an acceptable woman is about getting married and being attractive enough to land a modeling career, not to mention to get paid well for doing it.

Dr. Jolsen also mentions that she had no complications which I can speculate referred to either that the patient had no problems socially being perceived as female or that her new neo-vagina performed as it should.

Sexually and physically functional

Part of having a normal social life post-GCS depends on how well the neo-vagina or neo-penis functions. Professionals gauge its functionality on whether it can perform sexually and remove waste from the body. Appropriate sexual function is not only related to but sometimes assumed when one has a significant other. Dr. Boyd explains success for one particular patient.

I can think of a particular individual who is back dating [and] having sexual relationships and it is something that allows for her to live a normal life.

Having a normal life is about engaging in sexual relations as Judy Ingersol also confirms.

She came to see me this weekend and she is ecstatic and having sex with her boyfriend successfully and feels good about herself and I'm proud of that.

Dr. Jolsen explains how simple success can be.

I did the flap [for penis construction], flap worked, nerves grew, implant went in, patient happy, no complications, bang-bang-boom, done. Penis. Male. Happy guy. Has a girlfriend. Lovely. Very Rewarding.

Dr. Jolsen shows that when body parts work, when they are aesthetically appropriate for a patient's chosen gender and when the patient is using it, especially in a heterosexual relationship, success has been achieved.

In the absence of sexual relationships, the new body part should be aesthetically pleasing and function as Dr. Jolsen explains.

I examined the patient and there were no complications. The patient was peeing through the penis that I made. He had sensation in the penis that I made. He was ready to get a pump for erection through the penis that I made.

Professionals judge accomplished patients by how well they follow doctors orders and view having sex not just a sign of success but required to be successful. Sarah Elan explains.

Even that [vagioplasty] is not always good because they [trans-patients] don't use dilators enough, don't have sex enough. Many are not in a sexual relationship with a man. They need to get dilators out or there is a chance canal can close. They cannot find a partner. Major problem.

Patients use dialators several hours a day to ensure that their new vaginal opening will remain wide and deep enough to be penetrated. Sarah's account sends multiple messages to trans-people. She clarifies the importance of sex in avoiding physical problems with having sex. However she also solidifies that trans-people should have heterosexual sex in the context of a *relationship*. These responses reveal that the measurement for success related to trans-people is about the ability to have a functioning sexual organ, both in sexual encounters and basic waste disposal. Having a functioning organ is directly related to establishing and maintaining sexual relationships with others. What is most intriguing about these accounts is that these are the perspectives of not just surgeons but therapists as well. In other words, it makes perfect sense for surgeons to rate the success of their surgery on function of the newly constructed vagina or penis; however, therapists place equal amount of importance on functionality for patient success revealing how important sex is for a successful life in general.

In supporting the heteronormative order, surgeons also contradict the existing medical knowledge about identifying and appropriately treating trans-people. Dr. Boyd's account reveals this contradiction.

Some people [who] that are not sexually active [and] who do it [CGS] more for their internal sense of well being. But in general we want a cosmetically acceptable result and to function.

Dr. Boyd clarifies that regardless if patients have sex or not, surgeons want the new sexual organ to look and function as expected. What is fascinating is that he states that some, especially those who are not sexually active, may undergo CGS for internal gender concerns. In other words, he acknowledges that some may transition for reasons other than those gender-related and that perhaps sex may be a reason to have GCS. This thinking does not support the medical knowledge which indicates that those with gender issues are transsexual and only they should be allowed to have surgery. Another response I found of interest which in some ways goes against the medical knowledge is a quote by Dr. Callahan.

A far greater number of patients have SRS [sexual reassignment surgery or CGS] than facial feminization surgery. I don't understand this personally but realistically that many patients want female genitalia, their periods, babies all the misery of being female and going into female bathrooms rather than looking feminine.

According to medical knowledge and what many professionals have confirmed, appropriate patients for transitioning are those who believe themselves to be female rather than merely wanting to look like a woman. Dr. Callahan finds trans-people should be more concerned with appearing feminine to others and surgeries to transform body parts which most never see, is a waste of money. Most people do not see our genitalia while patients who desire to blend as females in society, at least this professional feels, should prefer to have facial feminization surgery rather than undergo CGS. Professionals are confused when patients want irreversible genital surgeries rather than facial surgeries

that may help them to socially pass as women in society. However I think it makes perfect sense. In our society, one is 'officially' a woman if one has a vagina. It does not matter how masculine a female may look, she is female for the sole reason that she has a vagina, even if it is not visible. Transsexuals are officially women if they have their penis removed. Trans-identified females know that facial surgeries may not make them look feminine but having GCS will make them legally female. So in the absence of or when noticable physical features which allude to a partiucular gender are non-existant, one can be officially a certain gender through legal documentation which is only acquired after have GCS. Although blending as a female in society is highly desired, it is not always guaranteed as some may believe that a transsexual is in fact a woman while other may be able to 'read' her as a transsexual and not a 'real' woman. However, having GCS, even if not visible to societal members, is the 'proof' that is needed to navigate into women-only spaces, legally. The procedures trans-individuals value are those which will bring them the most social rewards and priviledges. One's gender can be debated and challenged if one has only undergone facial surgery but it is confirmed once one has had GCS. How we view gender and what we believe makes an appropriate male/female body impacts the treatments trans-people desire. The fact that trans-individuals value GCS gives credence to the larger societal views about gender, 'factualizes' medical knowledge about transsexuals as found in the DSM, and establishes the appropriate process in which to transition as found in the SOC. This in turn provides support for professionals that these documents in which they base their decisions, is appropriate. Inadvertently, while this knowledge is maintained, other trans-identities or other ways to express one's

identity, such as transitioning from one gender to the other through surgery, is seen as unthinkable.

Conclusion

Whether professionals realize it or not, how they describe rewarding, difficult, successful and unsuccessful patients stems from the larger societal expectation about gender/sexual orientation and further sends messages to patients and others about what it means to be an appropriate surgical patient, an appropriate therapeutic patient, and sexual being. Practitioners' and therapists' accounts are reflective of the heteronormative order and solidify for other professionals and patients about how they must present and respond in future medical encounters. Decisions professionals make are complete and based upon existing medical knowledge, their desire to feel like good doctors, the larger gender dichotomy and expectations of being male and female, and sometimes, even to best assist their patients. Exploring exactly how doctors and therapists engage in this process and to what extent they provide patients the ability to make decisions will assist in fully comprehending the paradox to decision-making.

CHAPTER SEVEN

THE PARADOX: MAKING DECISIONS IN LIGHT OF OFFICIAL UNDERSTANDING AND IDIOSYNCRATIC USES OF KNOWLEDGE

The issues in chapters 3 through 5 demonstrate that treatment of trans-people is an ethical concern for medical and mental health workers. Making treatment more difficult is the lack of formal information available to health providers, forcing them to acquire knowledge by other means. Although both the DSM and SOC are official documents professionals use to help guide them in diagnosing and treating patients, therapists and doctors quite frequently disagree as to the content or application of these knowledge forms. Therefore, many use them idiosyncratically, often re-working them to make the most sense for accomplishing what they feel is their role in working with patients. Treating trans-patients using the DSM and SOC introduces a paradox. Using these documents legitimates decisions and means that the professional is ethical and therefore, a 'good' doctor, who uses established medical practices, techniques, and existing knowledge to provide treatment while simultaneously responding to individual patient needs. However, a professional who uses these documents strictly is a gatekeeper, one who holds all the decision-making power. Therapists and doctors do not want patients to see them as gatekeepers since patients may leave their practice and seek out another professional to meet their needs. Additionally, doctors and therapists do not want sole responsibility for decision-making. Therefore, to address this paradox, professionals

must relinquish some power and allow patients to have more input into the decision making process. However, providers who allow patients complete control are seen as unethical, dangerous, and therefore not doctoring at all. Doctors and therapists must carefully balance how much power to share so that they can escape full responsibility for treating trans-patients yet control the process enough to present the image of a good doctor. This careful balance reflects what I term “professionally-guided patient decision-making”. Providers begin by clarifying what they believe their role should be when treating trans-patients.

Re-Interpreting the Professional Role

As mentioned in chapter 4, mental health professionals identify real transsexuals and make decisions about who should receive transitioning services. Many do want to be gatekeepers to services much less want to carry the brunt of the decision-making process, especially when there is little support, much discretion on how to treat, and increased responsibility placed upon the professional. Not wanting to be seen as a gatekeeper, they clarify their purpose and reduce their power in the descriptions of their role, as Dr. Frank Jolsen shows:

If you look in the Oxford-English dictionary for the word doctor, it's Latin for teacher. My job is to provide enough education that people can make good choices based on sound understanding of the variable.

Dr. Jolsen shares how he enacts this role:

I do the same thing with every patient. I give them everything I got. I give them the benefit of a thorough education so they feel that they are making a good choice. I spend the time and I make myself available and I do the best work I can do.

Rather than deciding who should transition, health workers help patients make their own choices. He continues to describe how he does this:

[I] Gave the patient my cell phone number. It's important that you feel that you can reach me. It's important that you if have questions you find me. I don't want questions unanswered. I don't want you worried about things. I want to be sure that you have information 24/7 when you need it. If you're worried about something, I want to know about it so I can reassure you.

Educating and assisting the patient through the process is one role many professionals feel they must fulfill as opposed to gatekeeping. Therapist Brett Zelman begins with the patient as well:

I also understand the best I can where this is coming from and why it is the way it is. It is my job to just be with her [the patient].

For Dr. Susan Morgan, she must do a little more:

Well I think you have to get inside the other person's head a little bit. I mean, that's what doctoring supposedly is all about. I think I was really conscious of really wanting, making sure I understood their perspective.

For Dr. Morgan, finding out what patients want is more than just standing by and listening but includes getting inside their heads to figure it out. She negotiates between allowing the patient to decide while still establishing that she has some responsibility in making a decision for the patient. Rita Roberts, also a therapist, shares a similar point:

From their point of view they are the wrong gender and what does that mean for them and so my starting point is not well first you do hormones and then you read the standards of care and then you do this (snapping fingers)... my first experience, encounter with anyone I see, is to get to know them from their point of view... what are their issues and what do they feel about it and what do they want to do. Not everybody I see then or now has to completely transition. Some want to take hormones to see what it feels like and some people take tiny little amounts of hormones and there are life complicating issues that people want to talk about. "What do I do with my clothes, my wife, my kids? What if they find

it? They did find it. Now what do I do? How do I come out?" There are life issues that kind of organize themselves around gender issues.

Rather than applying merely one set of transitioning steps to all trans-identified individuals, professionals consider the path patients wish to follow. They take the time to understand what the patient wants and assist them as they begin the transitioning process.

Even if professionals ask patients for the paths they want to pursue, it is still the doctor or therapist who provides the knowledge, education, and 'encouragement' to move in a particular direction. Joseph Anderson, a therapist explains his role:

My role is really a consultant to the patient. I'm a consultant because I have worked in the field with hundreds of transgender folks. I have information, knowledge that I can give them in terms of making these decisions. I view my role now not as gatekeeper but helping them understand what their options are and making a careful thoughtful decision.

Nicholas Thomas provides another example:

I guess my role would be to help them to examine themselves and to determine exactly what they want and far along they want to go. And facilitate them getting to that point. I don't know how active I would be not so much a cheerleader as someone who facilitates understanding. Although with this person I have been seeing for a long time I was a bit more encouraging of her to do it because I had the distinct sense that she would do better and feel better once she did because she was pretty tormented.

Nicholas clarifies his role as a 'facilitator of understanding' although admits that he applied 'a bit more encouragement' because he believed that transitioning for this patient might be best for her. Joseph explains that he provides 4 options to his patients:

Again in my mind there is no connection between how they got here, what was their path to the gender dysphoria and the treatment. However they got there, here, I tell them there are 4 options. One is to do nothing. A second option, is to find some part time or partial gender change so that could be the transvestite, the autogynephile is married and once a week goes out dressed as a woman. I have executives that go home at night and put on a house dress and have cocktails with

their wife or they go out once a month to CGS or some other gender organization. So you can make the transition or make the gender identity that is sort of partial part time. And some people still are male but have been taking hormones for years but don't want the surgery and still living in the male role. So there are part time or partials for their resolution. And the third choose full transition. So those options are open however they got here.

While Joseph provides clear options for patients, he does make reference to the absence of a formal diagnosis to determine available treatments when he states "however they got here". In other words, regardless of how the patient came to identify as trans, the same choices about how to proceed are available. Joseph is the only respondent who indicated that one option he provides patients is to decrease or eliminate dressing or transitioning to the opposite gender:

One other solution by the way that I offer people is that this might be, typically someone who has been autogynephilic and cross-dressing has started to have feelings to change their gender one of the options is to say, one thing you can work on is to reduce your desire to change gender and stop cross-dressing. Gender community doesn't like this either. But it is an option because I have worked with people where I think it has been very clearly the result of a sexual orientation a paraphillia if you will and they look at the costs of that...people who were married, wife found out for the 3rd time that they were crossing-dressing and they had a choice..either I give up the behavior and the wish to change gender or my marriage. So I have had people who have chosen that path. Again, I don't have long term follow up but at least in the course of treatment it seemed to me a reasonable resolution.

Joseph recognizes that not only do patients have different paths of realizing their trans-status but that applying particular options for those who are trans may be inappropriate; trans-people must make decisions about how they would like to proceed since many factors, other than gender, may inhibit their ability to fully transition.

Professionals also clarify their role by describing what they do not want to be.

Brett explains his dissatisfaction with a job position change:

My job position was changed from sort of a generalist practice to a gender specialist and I wasn't pleased with that...because I was only doing assessments for hormones. I wasn't doing psychotherapy which is what I do. Well I'm clearer more than ever that I don't want to be a gatekeeper. I'm much more interested in helping a person explore what their options are and what goes on with them and their intent on transitioning.

For Brett and other therapists, deciding if a patient is a good candidate for hormones is neither what they were solely trained to do or what they particularly like to do as it makes them feel like a gatekeeper. Dr. Eric Friedland describes the role he does not want to play while treating trans-people:

So they see one person have success from some type of cocktail [hormone medications] and they want it. I tell them I am not a clerk. A clerk is a jerk...I am not a clerk. I am a physician.

Providing drugs without a medical evaluation for the sole reason that a patient wanted it reduces the importance of medical prescribing to that of a simple clerk. Physicians must balance between assisting their patients and with merely giving services on demand.

Giving treatments without using the skills for which they were trained diminishes the importance of medical and therapeutic work and can be seen as unethical, reflecting the struggle between wanting to be seen as a good doctor without being a gatekeeper.

Addressing the Paradox: Professionally-Guided Patient Decision-Making

Professionals often defer to patients in making transition decisions, especially in the initial diagnoses because professionals realize that some aspects of the DSM are outdated and the SOC is often idiosyncratically used. They may also take the lead from patients to relieve them of some responsibility for diagnosis and treatment with sometimes irreversible procedures. However, they assist trans-patients in various ways to ensure

that the decisions they make coincide with what they already feel is appropriate.

Professionals must control treatments and processes related to transitioning because not doing so would lessen their credibility and/or the existing knowledge (i.e. DSM and SOC) on which their decisions are based. At the same time, allowing patients to guide their treatment can also be seen as good doctoring as it reflects a person-centered philosophy. Respondents show how they employ professionally-guided patient decision-making in time and process, mental health issues, and preparing patients for surgery.

Ensuring Time and Process

Professionals struggle to ensure that their interaction with patients and patients' transition takes a particular length of time for what they believe is an effective process. Interactions which take time and reflect an on-going process where there is evidence of improvement or movement (transition) are seen as most successful. Time and process allow providers to feel confident that the services they are providing are appropriate. Many patients, on the other hand, want treatments immediately. Simply giving treatments to patients on demand diminishes professionals' role since their doctoring/therapeutic techniques are neither needed nor applied. If professionals take too little time then other professionals view them as being unethical, especially if they are not adhering to the minimum standards as outlined in the standards of care⁷. However, making patients wait too long may force patients to seek out other providers or make

⁷ The standards of care indicate that a person should have a documented real-life experience of living in the desired gender for at least 3 months prior to starting hormones and 12 months prior to undergoing gender confirmation surgery.

professionals feel that they are employing a gatekeeper role. Trying not to sound like a gatekeeper, Dr. Friedland explains why time is important for all patients:

If a woman comes in to see me to talk about hormonal replacement therapy because (of) menopause I am going to do the same thing if she were transgender. I am not just going to write it out. Here's what I can do, here is what it can't do. What are your risk factors? Are you high risk or low risk? It is the same thing with the transgender patient adults. They have hypertension, heart attacks, blood clots, etc. because I am putting them at risk with these medications and the patients need to know this. So every patient basically gets treated the same way. It's just that my colleagues would just put up a big cross and 'I can't do that'.

Dr. Friedland must justify why he does not write prescriptions for patients just because they want them. By comparing his treatment of trans-patients to other non-trans-patients he attempts to show that his techniques are acceptable medical practice and not evident of gatekeeping. Additionally, he presents himself as helpful and reasonable since, unlike other doctors, he at least agrees to treat trans-patients. Mental health workers also show strong support for process as Rita Roberts points out:

For someone to call up a stranger make an appointment and within minutes start talking about secrets and the most private personal stuff is a part of a process that I have a tremendous amount of respect for. So I didn't pathologize but I tend not to so I wanted him to talk to me about feelings and what it was like for him.

Her respect for the process of therapy extends to her treatment of her patients.

Time and process allows professionals to retrieve the information they need as well as leads to successful outcomes for patients, as Joseph Anderson clarifies:

Problems? It is usually because a person is being too impulsive and too pushy, not patient. That is why I keep telling people there is a path to follow for transitions and how you plan for it and think it through will make all the difference.

When patients do not follow a process then doctors and therapists are not surprised when complications arise for patients. Forcing patients to engage in this specified interaction, Dr. Jolsen explains, is really for the patients' benefit:

Generally we prefer to have patients who are interested in the gender confirming surgery have at least one letter to or be in the process of participating in the triadic process as established by WPATH, that is more of a practical issue of saving them time and money and expense. To come to travel to spend the money to have a consultation and kind of putting the cart before the horse. I think from a practical standpoint it is different so generally we prefer people to be kind of plugged in to primary care physicians who has been supervising their hormones and mental health professional who has been overseeing their therapy.

Time is needed to establish a process. What transpires in this process, especially because it follows the SOC, provides professionals with the confidence and support to make decisions and assist patients to make decisions.

Most professionals indicate that they take cues about treatment decisions from patients; however, they also uncover how much of their own input affects the transition experienced by their patients. Many times, patients come in with an idea of the direction they would like to go but are not sure of how to begin. Natalie Hatfield, a therapist, explains how she equips her patients with resources to transition.

Well how I am with people is grounded in client centered therapy which means that the client leads and I follow so in other words I treated her a specific way and worked with her in a specific way because of the things she came in with. So because this particular client didn't have any resources and was really kind of looking for concrete direction on what her next step should be so I gave her some resources. And told her about different organizations and different books and there is some kind of trans group at Central Community College [name has been changed] and she became involved in that so that was one piece of it and the other was to kind of be with her as she made sense of it having just found out this term and how it applied to herself and how she was going to tell her parents. We did a lot about when she was going to come out to whom and how that was going to look.

Although the client comes in with ideas and an overall direction to their transition, the steps are really laid out by the professional because, as Natalie explains, the patient is “looking for concrete direction”. Diane Olsen, another therapist, explains her approach:

What I try to do is create an atmosphere where that is really transpositive so it is always perfectly ok to express your gender any way so transition is a perfectly reasonable decision and not transitioning is a perfectly reasonable transition. And or to do what ever you want, it doesn't have to be a transition from one point to another just hormones, just top surgery, what ever it is. And I think that we had had enough interaction that that person saw me as just cool in that way. I think once people start talking about it I just try and give enough words out there that whatever they want to do will be ok with me. It's just a process of coming to a plan one step at a time to do whatever is right for them.

Diane Olsen believes it is for her to provide the words trans-patients need to discuss their gender concerns and that her interaction with patients should resemble a process. So while Diane speaks about merely creating an atmosphere for her patient to explore their gender, she goes on to explain that it is in fact a step by step process where she provides the terms to make it possible for her patient to do so.

A piece of the process that professionals wish to control is the timeframe in which patients transition. This timeframe depends on the individual professional and the particular patient. Natalie explains the importance of a proper timeframe:

Well the biggest thing I would say is I look to the person. In terms of them saying things like, I'm ready I want to do this, it is something I need to do so for her she knew that she wanted hormones at some point and had a bit of a timeline in mind but it was 6 or 7 months out so I didn't feel any pressure like oh my god I am going to have to be a gatekeeper here. So I wasn't pushing any particular agenda to make sure as opposed to if she had come in and said I wanted to start hormones next week then my time with her would have been different.

This excerpt elucidates professionals' interest in allowing patients to dictate their transition; however, if the patient makes decisions that are not aligned with what the professional expects, then they may have to override patients' preference. Patients are allowed to have more power in their transition as long as the choices they make are aligned with what the professional feels is effective. Natalie admits that had the patient wanted to transition quicker, then she would have approached the patient differently:

So over our course of therapy and at that time I was seeing her once a week she was saying things like she was looking up the effects of hormones she had come out to her parents, made friends so she was doing all these things that let me know that she was preparing her life and the people in her life to deal with the changes in her body and her brain that were going to happen once she started taking these hormones. And she also over naturally came out more of her story and the things she had done that led her to believe that she was in the wrong body and what her wishes were and how she would feel better if she looked more like the woman she knew she was. So it's kind of like I was looking well I had sort of a checklist in the back of my mind but I didn't have to push the agenda because she had given herself time and all those issues had been brought up.

Natalie states that she does have an agenda to treating patients and that as long as the patient initiates the time they spend together addressing these agenda items, then she does not feel she has to 'push' her agenda. I asked her what her checklist consisted of so Natalie continued:

I think like the things I just talked about. That when did the person know or begin to suspect that they were different? And what kind of things did they do to correct that difference if anything? What kind of other experiences did they have in terms of crushes or dating relationships, what kind of social support does the person have? How high functioning are they? Do they understand the implications of taking hormones or surgery? Are they at a point that they can start changing their appearance? Do they want to change their name so kind of like a readiness and an understanding of the possible consequences of making these transitions and if they understand the consequences are they in term of internal and external support deal with maybe negative consequences.

Natalie fully explains what needs to be addressed to prepare patients' transitioning, what must take place during the therapeutic process. She felt that if these things did not get addressed or if the patient was moving too quickly in her transition then she would have to approach the patient differently, more as a gatekeeper:

So I've never had to somebody that I don't think this is a good idea but if I did it would be very much be along the way so I wouldn't approach it that I was holding out the whole time but I would express my concerns at the get go or whenever I would be worried. And so then it came out naturally and then I could go whew! But if we had gone a few sessions closer to her leaving then I would have brought it up and would have said I'm really concerned because I know there are things...and I'm just wondering if you had thought of that kind of stuff.

She displays patience in her interaction with this trans-patient in hopes that her concerns will be the concerns of the patient and come out 'naturally' in therapy. If over time the therapist's concerns are not brought up by the patient then she would have to bring them up, especially if she felt that her time with the patient was limited.

Although professionals look to the patient to provide stories, as mentioned in chapter 4, and guide the doctor-patient interaction, it is still directed and controlled by the professional as Rita Roberts shares:

The Harry Benjamin standards of care whatever it's called now, you know it was important for me to read up, I also had very, not everybody, but I had very informed people who would, we would talk about where we were. It's like when I worked early on with people who had HIV and AIDS, people by necessity had to really informed to what was going on early on with the virus and still because if they weren't on top of it they ran the risk of getting not the care that they needed to have. So many of the people you know would come in with specific requests and you know I would say I don't write letters on demand. I do write letters and let's talk and then.... My initial thinking is let's sit down and talk. I tell a person because I don't write letters on demand that we need to sit down and talk and because once in a while I do have somebody who comes in and isn't there yet. They are not to the point of hormones. They want to be a woman now (snaps fingers). "I am a woman. I want to be a woman. I want breasts." And so we

talk. I have never turned anybody down from writing a letter. I have told a lot of people that a letter comes out of our, my conversation with you about where you are and that is so you won't wind up in a situation where you are ahead of yourself. And when I write letters I always have people, I give it to the person and [ask them] "this is my draft. What do you think?" And we will use it as part of a whole process. So I think as a therapist I don't it's like let's sit down and talk.

For Rita, the process of sitting and talking to patients, including time and involvement is necessary to provide appropriate services. So while she does not deny patients access to transition-related treatments, she ensures that the process occurs at a pace with which she is most comfortable. Her previous thoughts and those in the next excerpt show that the therapist has the knowledge to decipher if one is 'there yet'. Coming to this decision takes time, and professionals who do not respect the process and time involved in arriving at such a decision are just 'setting up' their patients. Rita elaborates:

I supervise a psychiatrist who is seeing a person who is wanting to transition from male to female and he, she, he's probably been on hormones for 3 months and is trying to have surgery and found a surgeon who would do it. Now what, what, what is that about? That is a set up. This person is obviously not there yet and someone is willing to just go ahead with the surgery.... It was eye opening for the psychiatrist I supervise who is seeing this person for me to say you know YOU have to be familiar with the standards. You have to educate yourself so you can help this person to understand the process.

The SOC indicate that therapists should use the steps as minimal guidelines and not as concrete rules. Aware of this flexibility, Rita does not waver from the number of hours a patient is expected to meet with the therapist but does decide that the number of times may change. Rita continues:

I think part of what I try to do is I don't really give active resistance to people. Because I really believe in their autonomy and what I have found over time is sometimes people come in and if they and can almost come in combative because they think I'm going to do this [deny them services] but then kind of go all right

tell me, and they can see that I'm not going to go 'No, No, No'. I'm realistic with them, part of the standards of care is clear that someone has to come in like 12 times or something and if I'm a little hesitant I might say well there are these standards of care and yes they are guidelines and they all know that and if someone comes in combative they really know what is in those things [SOC]. So I'm not asking them for anything that is unreasonable and I'm kind of saying to them we will see how it goes and I'll give people the option of do you want to come in once a week or do you want to come in every other week or once a month so I really try to work more collaboratively and when people pick that up that combativeness kind of drops and what I might get instead like someone will disclose something but then be quick to back track from it to make sure that I'm not thinking there is a pathology that is going on to prevent them from getting something.

Rita knows that since patients are well-versed on the contents of the SOC, they are careful not to disclose things that may set up red flags, such as co-morbidity as this may be a reason for therapists to deny or delay writing a letter for GCS. Patients know that mental health issues may disqualify them for services; therapists and doctors take patients mental health into consideration as they make treatment decisions.

Professionals also want to assure colleagues they follow a process or at least can create the perception that such a process is taking place. Before performing surgeries, especially CGS, surgeons expect a letter from a therapist to reflect that the mental health provider spent considerable time with the patient and followed a certain process, as Dr.

Susan Morgan indicates:

If it's [letter] a luke-warm...you know, if the therapist or something says "this person is psychologically stable and ready to move forward with surgery" or whatever. They need to give us a little more than that. We need to hear about their history, the details of their life, what's really going on...it almost sounds like the therapist is rubber-stamping it but yet they don't necessarily agree with the process. It's kind of like the unsaid stuff, it just doesn't read as authentic...I'm more likely to question it.

When letters do not convince the surgeon that the procedure is a good choice, they simply send the patient back to retrieve the information they do want. So to avoid wasting time, sometimes therapists, as Brett Zelman explains, tell patients to find out what the surgeon wants prior to writing a surgery confirmation letter:

I tell my clients, “Check with the surgeon about what the surgeon wants [in the letter] and then tell me.” I just wrote a letter yesterday for a surgeon who is working with this particular client’s primary care doctor and basically, as far as I can tell, all the surgeon wants to know is if this person is in therapy, and for how long. I can attempt to give a diagnosis; and I did add a little bit about the process by which the person has come to the point with wanting therapy, I mean surgery, and why I consider this person appropriate and ready for surgery.

This account reveals that collaboration between professionals increases their dependence upon each other, which can be perceived by some patients as an ever-growing gatekeeping power. On the other hand, pushing the decision-making onto colleagues may reduce the amount of pressure one experiences when making decisions, as Dr. Jolsen describes:

I send them back to the therapist. And I would actually call the therapist and say, “Look, I know you wrote this letter. But I’m getting this vibe from this patient and I think the patient needs more work.” And that’s not common because the therapists nowadays are pretty savvy and know their jobs and do their job. But if I see a patient who does not impress me with their psychological stability, I’ll send them back to the therapist. And I can do it easily by saying, “Look, I got this letter but it’s not exactly what we need. So I’m going to talk to your therapist. Go talk to Dr. Jones. And when she writes you...when she clears you the way I need you to be cleared, we’ll go forward.” And I can put it back in the psychiatrist’s lap or the psychologist’s lap and I call them up and I say, “Look, I need this very specifically from you. I need to know how will this patient do when things go down?”

Although surgeons want therapists to make the decision that a patient is appropriate for surgery, they really have already made the decision as to whether they will treat this

person; perhaps surgeons just want the mental health providers to write what the surgeon already believes because their diagnosis and approval carries more weight, reflects the what is outlined in the DSM and SOC, or because they are better trained to make such a decision. Nicholas Thomas, a therapist describes this:

Not much she [patient] was I mean she knew the surgeon to talk with she was involved with [a known doctor who treats trans-patients] so really it was really just about standing by and endorsing all the steps...I have the benefit of being acquainted with and in close proximity to Marcus Little...I would always involve him so I don't have to keep that data [who is appropriate for surgery] in my head.... If I have a question I might give him a call.

Nicholas reveals that it is the surgeon who really knew more and that he was really only there to 'endorse all the steps'. He also shows that this collaboration was facilitated by the patient. Hence, patients must engage in legwork to get their needs met and professionals must negotiate with each other to meet patient needs.

Some surgeons are incapable of making diagnosis decisions as Brett Zelman states:

They're [medical practitioners] not equipped. They're not equipped. So the sorting out of "is this person appropriate and ready for hormones?"

Brett feels that since many medical providers are not trained to recognize who and at what point a patient is ready for hormones, they approach therapists just to receive the 'ok' on a patient. However, they create challenges in accomplishing therapeutic work, as

Kathy Grayson shares:

In other words, at that time the surgeon wanted to have a mental health practitioner's opinion on whether it was a good idea to go ahead with this surgery. That is not a position that I like to be in. In other words I don't want to be the one making that judgment. It seems like in some ways it is a sham; in other words the person sitting with me is there to basically convince me that this is a good idea

and there are no problems and I only know what people tell me and so it is not particularly meaningful.

Meeting with a patient just to make a diagnosis or decision to continue with transitioning procedures diminishes the importance of therapeutic work and asks the therapist to make decisions without the two things they need: time and process. She continues:

Well because that is what they [patients] tell me, you know my doctor said I have to do this and I don't know why I should have to, and there is a part of me that agrees with that; in other words I don't necessarily want to participate in that kind of interaction but I mean these are also people where they if they are really facing surgery and transition then they had to be in surgery with somebody else. In other words there is a process normally that people have to go through to explore what they are experiencing and make sure they have thought of everything, that they're mentally relatively healthy etc, and just being called in for an opinion is really just going through the emotions really... Well as I said it doesn't feel particularly meaningful. I guess I try to be straight forward. In other words let's be clear about what this is about, what the person is hoping to get from this interview and from this time in what way could be helpful, what they are looking for and at least try to have an opportunity to explore to make sure it hits some of the bases of what they are anticipating, and how realistic they are being and really for the individuals sake and not for me to pass judgment.

Therefore, the expectations of identifying and treating patients as outlined in the DSM and SOC create a paradox for mental health professionals. They are asked to diagnose as required by SOC, using the DSM, but asked to do so quickly and on demand by a surgeon who has really already made the decision, both which go against the point of therapy.

Recognizing Co-Morbidity

Professionals must officially diagnose for trans-patients to access services and surgeons require a diagnosis to perform surgical procedures. As shown in the previous chapter, definitions and the treatments allowed for a particular diagnosis were narrowly

interpreted; only ‘true’ transsexuals, as identified by a professional, were considered for GCS. Therefore, it was the job of the therapist to weed out true transsexuals from those who were merely cross-dressers, as only true transsexuals were seen as being appropriate for GCS. Although the DSM-IV-TR still supports a clear distinction between those with TF and GID, some therapists and physicians are beginning to see diagnosing and their role in doing so differently. Despite the fact that professionals’ gatekeeper role in diagnosing has diminished and that many look to the patients to self-diagnose, respondents articulate that it is still their responsibility to identify patients with mental health concerns which could disqualify them from a GID diagnosis and treatments.

Joseph Anderson explains:

The other big change in terms of the gatekeeper notion is again in the beginning I really did view my role as a gatekeeper. I needed to make a decision about whether this was the right course of action, GRS [gender reassignment surgery], was the right course of action for this person. Over the years I’ve come to a very different view which is essentially that if someone comes into my office and as long as they are mentally competent to make decisions about their life, that they are not mentally incompetent, not committable, that is a pretty high standard it is their choice as to what they do. I also view my role as identifying other issues, perhaps mental health issues that need to be addressed so that they can be transgender and be depressed, transgender and have a substance abuse problem. So that is another role I see. And then once they sort of thought that through and made a choice to help guide them through that process based on my experience of people who have gone through gender transition.

What is telling about this account is that Joseph begins by explaining his role of simply ensuring that his patient is competent enough to make a decision. However, he then explains his role as providing enough information for the patient to make a ‘careful, thoughtful decision’ based on what he believes are available options. Finally he feels it is his responsibility to then identify any other aspect of life which may affect the decision to

transition and to recognize any mental health concerns which could disqualify the patient for transitioning services.

Professionals who take the responsibility of ensuring that patients can make their own decisions about transitioning believe that underlying mental health conditions may interfere with patients' ability to handle aspects of transitioning or may cause them to make poor medical decisions. While some professionals may deny services, others work to stabilize the patient enough to make their own decisions again. Brett shows the interesting relationship between hormones and stability:

Someone who is emotionally very unstable...if there is any way to help them stabilize before they start hormones because transitioning, emotionally, is very very challenging and hormones are challenging. So if there isn't enough stability in their life to support those challenges, then I try to do whatever we can do to help them stabilize. It's not always possible and sometimes what's most stabilizing is getting them on hormones.

Brett reveals that it is not always the best choice to deny hormones due to mental instability but that hormones may actually *need* to be administered for the patients well-being. Joseph Anderson also elucidates the importance of stabilizing but not denying treatments:

The only times I have not supported surgery is when the individual had a serious mental disorder, like, serious depression. I had one only real psychotic individual, so there have only been a couple cases where I said that I don't think you should do this now. See my approach in that situation is to treat the underlying mental conditions to the point of some stability and then re-evaluate.

On the other hand, some professionals feel that depression and underlying mental disorders are a result of patients' concern with their gender and transitioning. Dr. Nicole Pruitt explains what she believes is the appropriate response:

Well they (prior endocrinologist the patient saw) were concerned because the patient suicidality meant that she wasn't really ready for hormones therapy... [I provided] Empathy and she was getting estrogen off the internet. A lot of them do that. They get it, they don't need a doctors prescription and they get it from foreign countries and there are ways to get it off the internet so I gave her a prescription and followed her because I felt it was safer for her to get prescription medicine that I was monitoring rather than buy it off the internet and she did pretty well.

Dr. Pruitt felt that harm reduction was better than letting her self-medicate, therefore justifying that treating people, despite guidelines to the contrary, was ethical.

Many patients are savvy in that they know that displaying mental health issues can disqualify them for services. Natalie makes this point clear:

Like just a few weeks ago I was sitting with a client and she said something about and she is in a real life experience year and is looking to get SRS sometime in the winter. And so fairly soon we will have to start working on her surgery letter and she said "Sometimes I'm really paranoid that people are reading me. And I know that I just get it really freaks me out and then I get much more hurt when someone makes a comment and I think they read me and they slam me and it really pisses me off"... and then she just kind of stopped and said "Well you know it is not that bad, it doesn't happen a whole lot"... and I just stayed with her and said "Yeah you know sometimes triggers and it really gets you but you don't go through life that way in general. You are not walking around paranoid all the time"... and she said "Right, right"...[She was assuming that I thought] That she was walking around way too paranoid and had not gotten to a place inside where she was mentally healthy enough to go through SRS, that is my assumption.

While patients are careful in how they present their problems to physicians and therapists, professionals need to respond in a way so they can receive truthful responses from clients while still recognizing those who are in fact too mentally ill for treatments.

Mental health conditions can affect a patient's ability to make a sound decision regarding surgery but also the ability to cope with typical surgical stressors. Dr. Alex Boyd makes this point clear:

The importance of appropriate pre-operative evaluation and assessment...it is not that we would necessarily refuse to operate with a pre-existing mental health condition but we do want to make sure that person is under appropriate treatment and the condition is either stable, or whether through therapy or medication because surgery is a stressful time and it is going to it can certainly unmask pre-existing issue so we want to know for any elective operation that things are kind of ok, that you are at a good place, mentally, economically, for all sorts of reasons because surgery is a stressful time.

He continues.

Sometimes you are not a candidate for surgery, maybe because you have put an undue attention on a specific body part. My nose is too big, I didn't get a job promotion, my breasts are too small, my husband is leaving me, maybe not exactly body dysmorphic disorder but undue relationship on a particular body part is objectively not problematic. Those few things such as pre-existing mental illness not treated, co-morbid medical conditions that would make surgery too risky. So very similar issues.

Hormonal management is important. Doctors will not proceed with GCS unless a patient is under the care of a physician. Patients' drug dosage needs to be managed before undergoing surgery as particular drugs can create problems during surgery as Dr. Boyd explains:

I don't specifically do the hormone usage but one thing is that we refer them to our medical colleague then if they are getting the hormone off the website and not under medical supervision, then we would certainly not proceed with surgery. We would ask that person to see our primary care physician to get medical and hormonal management and make sure that dosages are correct and accurate. You want to know what someone is getting and make sure there is not going to be unknown interactions, unknown compounds in whatever they are taking whether it is herbal supplement that can cause bleeding, that can interact with the anesthesia. There is also the concept that after surgery you have to follow some directions. There is dilating, there is douching, dressing changes, and someone comes in already working outside the system that may be a red flag that someone is not willing to adhere to the post-operative regimen that we have.

Knowing the types, amounts, and where patients acquire their hormones will not only assist doctors in reducing the possibility of surgical complications, but patients receiving

them from an unknown source is indicative of how well they may follow medical directions post-surgery. Those who have already proven that they will work outside the established medical system to access hormones, may not follow orders after surgery.

Preparing Patients for Surgery

Professionals do not feel that patients can make appropriate decisions about transitioning, especially undergoing GCS, unless they are equipped with information about the realities of surgery and post-operative healing. Dr. Morgan, while admitting that she uses the SOC fluidly, feels that not using them would be irresponsible:

Yeah, and the reason is that the transition itself has...there are two components to it that I think are...are troubling. One is that there's a lot of impulsivity associated with that and kind of euphoria. As a person lives a life that they never imagined and then their imagination runs, they, I don't know, it's like...I think anybody who goes through a transition has delusions of beauty or that kind of thing. Where they think there's so much...they're really...or manliness or whatever...there's kind of a delusional period that goes along with it. And secondly, there are a lot of psychological consequences, because transition is not easy. It is very, very difficult. And...so it puts a lot of stress on your own psychological well-being, that's really the issues. Not that it's a psychological condition, which is the unspoken message that gets out to the public, unfortunately. But the fact that there are...it tests your psychological reserve. And there are a lot of people that transition and they had no psychological issues before, but the transition brings out a lot of things that...they need somebody there who is going to be unconditionally supportive, at least get them to keep the...balloon tethered kind of thing.

According to Dr. Morgan, patients need professional support in order to make a life-changing decision such as undergoing GCS. Even if a patient is not already 'delusional' about their transition, the process may certainly create psychologically stressful issues. Joseph Anderson feels that particular practical information needs to be presented so that patients can make the best decision:

One of the important issues is to have a really informed choice, is to have realistic benefits and consequences so for MTF you have to explain although we can take the penis off you will not have the same sexual sensations. That if you are taking hormones and remove the testicles your sexual desire will decrease. That they will make less money at their job because they are now a woman. That relationships may be difficult to find and maintain. Those are the main consequences and there are more medical consequences of taking estrogen so forth. But for FTM we have to remind them the same thing, that the genitals do not work the same. Just because they have a phalloplasty and create a neo-phallus it doesn't work the same. They don't have the problem, now as male of making less money. But they have to expect that they will develop male pattern baldness so I tell them to look at their fathers and their mother's fathers in terms of their hair pattern because that is what they are likely to have. Same issues in terms of finding relationships FTM typically do better in finding partners.

Dr. Boyd points out more realities of life post-surgery:

Perhaps expectations either were not addressed by the other surgeon or there was some communication break down where there was a misunderstanding as to expectations, for example, scars. Any surgical procedure produces scars and scars are permanent. There can be issues with numbness, associated issues with orgasm and post-operative sexual function. And those are things we try to address in the pre-op period because these can be very common issues and expected issues as opposed to unanticipated outcomes.

Professionals adjust the way they approach patients based on previous patients' post-operative concerns. After years of experience in working with trans-people, Diane Olsen feels that her discussion of surgical expectations needed to be more formalized:

I now have some formalized, for example, I have [a] form where I go through reasons why not to have surgery that have nothing to do with gender and realistic expectations for surgery that I actually read in session with the person because I went through so much surgery with so many people that when done said 'I couldn't believe how much it hurt or how incapacitated I was' or they got really upset because it didn't look like what they wanted it to look like in the first week so I written a whole lot about preparing people for surgery. So that specifically I have become better at and it is much more regimented for me. I give people things and they sign things together.... Yes expectations, all kinds of expectations to be better prepared, because I used to spend months, weeks, or years talking to people about surgery and then they would still come out of surgery and say 'nobody told me it was going to hurt'.

When I asked her to explain specifically what expectations she covered, she elaborated:

One is that you won't know what the result is for 6 months to a year. And that because I had a couple of people that didn't like what they had and they went to doctors in their local area who charged them huge sums of money to fix what really might not have been broken at all. I mean I could just give you a long list of all the things to do wrong before and after surgery and of course I work with are not going to have surgery, most people don't. [The] majority of people in the world are not having surgery and yet I work [with] people that are.... People I think get uncomfortable with the topic but I think there are things like really good reasons not to have surgery that have nothing to do with gender like if you don't have enough money, if you have an illness and not in good enough health, if you have no tolerance for pain or for disappointing surgical results, or scarring or if you were going to have genital surgery but you knew that if you weren't going to be orgasmic you would kill yourself, you shouldn't have that surgery because some people lose that ability to orgasm. You have to be really able to tolerate, you have to be really resilient. And I would say if you are on the verge of a nervous breakdown, if you are in some kind of an emotional fragility... I know people that were in really good shape and it broke them down.

Discussing realistic expectations allows this professional to assist her patients in making an informed decision regarding GCS. Dr. Jolsen clarifies that giving this information to patients is more than simply getting them to understand the risks and complications but that it is his job to make sure they have a full understanding:

[I have] Discussions of risks and complications. Making sure that they understood what I was saying. It's a difficult thing to quantify. I can just tell you qualitatively, that we just kept going over things until I was sure that the patient had a really complete, thorough understanding of what's involved... It was not a matter of understanding. It's a matter of being sure that they have a full and complete education before they make a decision for something that potentially could be very devastating surgically.

Beyond informing patients about the pros and cons of surgery, some professionals stress that surgeries will not solve all the patients issues. Sarah Elan supports SOC guidelines

to take time through the transitioning process so that surgeries, perhaps inappropriate for some, are not hastily undertaken:

You know SOC? One lady doesn't think one year of cross-dressing is appropriate. But many of my patients are glad we did not rush into surgery. When we remove the testicles we can do lower doses of estrogen and maybe don't go through surgery. There may be other health issues, not good candidates for surgery. Many appreciate that when they were griping and complaining that we didn't rush. Many have surgeries without formal approval and many regret it like if they have a hysterectomy. These surgeries will not answer their problems..This time allows this person to get their family to understand or accept. If there is not consensus, we will not go ahead. Families need time to come to terms with it and patients many come from troubled backgrounds and I think this person was trying to get back at her mother. That's not mentally healthy. Even if family cannot accept it but my patient needs to accept this will not get better.

Professionals believe that patients need time in making a decision to have surgery.

Professionals take on the responsibility so that patients do not make disastrous, irreversible decisions. More than just making sure that patients really want to *be* the opposite gender, they have to ensure that patients are aware of how the surgery will affect them physically, emotionally, psychologically, and socially. Forcing patients to adhere to a specific time and process may make them thankful later, although patients may not be ecstatic at the time.

When Treatment is Not an Option

At times, when professionals are incapable of getting the patient to the point of making a 'good' decision, they must decide to terminate the relationship or withhold transition-related treatments, as Brett Zelman explains:

They could have dressed in a way that...maybe they would have looked like a butch dike but they could have passed [as a woman], you know? Um...barely dressed at home...there just wasn't enough experimentation going on to, in my mind, [to] warrant hormones. And so I did not give the go ahead for that. Again,

someone who is not compliant with medication they are already on...to me, that's a big problem.

Brett's refusal to provide hormones is based on past patient behavior. Patients who do not follow the process by which he expects, that a patient should dress as the opposite gender frequently, may not be serious about their transition. Additionally, someone who cannot follow doctor orders and take previously prescribed medicine, he feels, will probably not comply with his orders.

Many times professionals, especially surgeons, do not want to treat patients if they do not have access to post-surgical physicians. Often time, doctors who treat trans-people are difficult to find. Many patients have to travel many miles, at times even out of state, to find someone that will treat them. Dr. Jolsen shares the conditions in which he terminates a relationship with a patient:

I refused to take care of the patient unless the patient had a doctor in-state, in their home town that would be willing to provide care back home. I cannot care for the patient 1200 miles away. I was unwilling to...I was unwilling to assume full responsibility for this patient long distance.

Professionals feel that patients need other professional support nearby, especially post-CGS. Some professionals do not want to treat people if the patient will have to solely rely on them or cannot receive any after-care. Medical workers need collegial support when treating patients as they do not want to be the sole practitioner responsible for transitioning patients.

Mental health professionals may refuse treatment, at least temporarily, if they find that other aspects of a patient's life cannot handle a transition. Brett shares about one patient who had developmental disabilities and had no means to meet with him:

But I would be concerned about where that person was living and could the living situation handle a transition.

Brett continues on the same idea about another patient who was homeless:

Once a kid is living on the street, their life become chaotic. A chaotic person is very hard to provide services to.

Often, professionals must refuse to treat or put off treatments due to entenuating circumstances that have little to do with the psycholgoy or medical condition of the patient.

Patients often feel that they must present their concerns to professionals in a particular way to get what they want. Many providers are aware of this; however, while they may expect some level of patient story-telling to get what they want, surgeons are not keen on dishonesty as Dr. Jolsen continues:

The patient was lying to me... The patient said, "I had some reconstructive...I had a problem with surgery," didn't really tell me what it was, didn't use any really important words. Just said that they had a problem with surgery and they were looking to have their penis fixed. I was immediately on my guard and I said, "Well what kind of surgery did you have?" "Well, nothing really important. But I had a urinary tract problem and they tried to fix it." He refused to tell me that he was a female to male transgender patient and who had some surgery... Refused to tell me the truth. When I finally said, "Well I'm examining you and I'm seeing the scar on your forearm [where skin is usually taken for a graft], and I'm looking at this penis you have, and the scars on your chest [mastectomy], and what I am getting from my exam and what you're not telling me is that it seems to me that you are a patient with gender identity disorder that you have been treated for" and he completely denied it. And I said, "You know, I can't work with you. I'm sorry. Find another doctor, somebody with whom you can be truthful. Because unless we have an open amount of interaction, I'm not going to help you." And I turned that patient down... The patient was not truthful. I can't help somebody if they're not truthful... I said, "You need to find a doctor with whom you can be truthful because this kind of stuff requires a very truthful relationship with your doctor. And you got to be straight. And if you can't be straight with me, then find somebody you can be straight with and good luck.". "Uh...I'm sorry...ummm..." "I know. I'm sure you are. But I can't work with you if you're not honest. So, talk

to some other doctors. Think about the kind of relationship you want to have with your doctor and if you decide you want to have the kind of relationship with your doctor that I want with my patient, I'll talk to you again some time, but not today."

Building a relationship is important for the professional who wants to make responsible decisions as well as build a good rapport with the patient. Some doctors need to both like their patient and feel that the relationship is built on trust, as Dr. Jolsen continues:

I have to like the patient to take them into my practice. If I don't like them, I will turn them down. I have to like them personally. I have to have a good feeling. I have to have a rapport and I have to like the patient...: It depends on what the letter [letter from therapist that one has GID] says and how I feel about the patient. I've been doing this long enough now that I pretty much can form a good opinion on my own. My concern is that the patients do not have multiple personalities, they're not schizophrenic, that they have a personality structure that is intact enough to not just to undergo the transformation but also to handle devastating complications that could occur. Anybody can handle it when it goes well, I want to make sure they can handle it if it goes badly.

Professionals want to be effective doctors to best assist their patients and because it benefits them, as well. Strong doctor-patient relationships are useful not just in providing the best support for patients if complications arise. Ensuring that patients like the doctor is most crucial when there is a possibility that patients may be dissatisfied as Dr. Jolsen shows:

I guess what I have to be is more careful that they understand the partnership. I have to win them over so that even if I weren't on their insurance plan they would still choose me.... Because when everything goes right, it almost doesn't matter. Ya know, the doctor that has a really crappy bedside manner, who nobody likes, but who gets a great result, nobody cares about the bedside manner. Nobody cares about the relationship between the doctor and the patient when everything goes perfectly. The time that the relationship between the doctor and the patient is so critical is when things don't go perfectly. And that happens.

A doctors' good bedside manner becomes increasingly significant when patient expectations are not met. A good relationship with the patient may help to reduce the stress associated with possible medical problems. However, as Dr. Jolsen explains, even without medical complications, a solid connection with your patient may not reduce the issues which can arise related to patients' social complications:

So you can have the best interaction possible with your patient, you can perform the best surgery possible with your patient, you can have the most perfect physiologic result with no complication and their lives still may be a mess, because of social factors that are outside the scope of patient-doctor interaction.

Sometimes the tools professionals use to decide on appropriate surgical candidates prove useless as therapist Sarah Elan shares:

I have one kid that I am sure we should have not have allowed him to have surgery. He was never happy with any surgeries. He was horribly abused, sexual and emotional by his father. Mother never protected him. There are some people that we have approved for surgery....last month a MtF [male to female] came to see me, border personality disorder, cutting, I said I am not going to approve surgery, she is a basket case, but she had it and the last time I saw her I liked her!!!

For Sarah, someone who will not be happy with results should not be allowed to undergo surgery. On the other hand, Sarah finds that even despite obvious co-morbid red flags to not continue transitioning, she believes that the second patient was a good candidate for surgery, especially because as she states, she liked her. These examples reveal how professionals decide to not treat patients. Professionals may refuse to treat because they do not feel patient decisions are appropriate. Professionals also refuse to treat patients if they cannot develop a solid doctor-patient relationship. Lack of a strong relationship can add to professionals' work because if the patient is not satisfied with the surgical, social,

physical, or psychological result, it is the doctor who will have to deal with the problems. However, as the final account shows, sometimes, even when professionals make their decision based on the existing knowledge, experience, and intuition, it still causes problems.

Conclusion

Professionals must grapple with how to make appropriate treatment decisions in light of their individual comprehension and use of official documents, especially because of the lack of formal knowledge and subjective knowledge professionals must acquire. Treating trans-variant patients introduces a paradox for health providers who employ professionally-guided decision-making to rectify some of these concerns. Professionals must make decisions as ‘good’ doctors but not as gatekeepers. To balance this, they must share a piece of the decision-making process with patients. Medical and mental health workers begin by re-articulating what they believe is their role in treating trans-patients. Not to be seen as gatekeepers, doctors and therapists explain their position as those who assist, educate, and guide the patient. It is this re-interpretation of the role that allows professionals to be seen as a good doctor. One reason professionals defer to patients is because of the ethical issues involved with this type of treatment and because there is no clear medical or psychological ‘proof’ of appropriateness for services. There is no physical sign to indicate that a particular patient is a good candidate for surgery or hormones. Doctors do not want the decision to rest completely with them due to the lack of clear formal knowledge or collegial acceptance in treating trans-people in mainstream medicine. However, professionals must show that they are contributing to some aspect of

the decision-making process to retain power and control as ethical doctors.

Making treatment decisions also forces professionals to interact in interesting, often contradictory ways. Technically, surgeons need letters from therapists to verify that a patient is an appropriate candidate for surgical interventions. Getting this letter is not only supported in the SOC but relieves surgeons of being the only person to decide that a patient is appropriate for treatments. More than just referring to mental health providers for an actual diagnosis because they could not make such a decision, they referred to them because the letter was crucial and perhaps provided more official weight. Surgeons often dictated to the therapist what they needed, often even telling patients what they should tell their therapist that the letter should contain. Additionally, many mental health providers, to save the patient time, would recommend that they find out exactly what the surgeon wants so that they could provide the necessary information needed to obtain surgery for the patient.

When medical and mental health workers did not feel comfortable with making decisions or treating patients because the various issues mentioned could not be effectively balanced, they simply chose to not treat. Many doctors and therapists would not treat patients who did not meet the requirements or who did not engage in a suitable doctor-patient relationship. Any patient who could not make the professional more comfortable with treating them or make them confident in the decisions they were making would be turned away. The outcome of the doctor-patient encounter depends on many components. Diagnosing and treating trans-people results from professionals' understanding of existing knowledge, experiences with previous patients, and their desire

to feel good as doctors by balancing pleasing both patients and the medical/psychiatric community.

CHAPTER EIGHT

CONCLUSION

This study speaks to the ways medical and mental health providers make treatment decisions with trans-identified patients. Their idiosyncratic interpretations and application of formal knowledge demonstrates how professionals organize their work and assist patients. How they arrive at particular decisions reflects their struggle between perceptions of a good doctor versus a gatekeeper. Decisions often have less to do with particular patient behavior and more to do with extraneous factors which affect professionals' day to day work. Through their actions during medical encounters, health care workers often re-work yet simultaneously legitimize existing medical knowledge. Additionally, while providing opportunities for trans-people to live in the desired gender, they perpetuate traditional meanings of gender and establish what it means to be a successful trans-body, often solidifying that there is only one path to being Trans. Below, I summarize my main findings, analyze the research, and then suggest implications for medical knowledge and policies.

Knowledge Paradox

Both the lack of formal education and the disagreement among community members about best treatments forces professionals to find alternative ways to gather knowledge. Medical and mental health providers gain information by collaborating with colleagues, through trial and error, self-educating, and listening to their patients. The

absence of solid knowledge about how to diagnose and treat means that providers must search for ways to learn how to best do their job. Lack of knowledge encourages collaboration between professionals as collegial support legitimizes decisions as both ethical and appropriate. While physicians and mental health providers view interdisciplinary teams as needed to best assist patients and guide their work, they must justify that connecting with colleagues is in the patients' best interest and not meant to solidify their role as gatekeepers or make patients jump through unnecessary hoops.

Alternative knowledge acquisition, especially previous experience, assists professionals in making decisions with patients. Many make decisions based on their "intuition" and just knowing if patients are "there yet". In fact one surgeon indicated that he knew the person he performed GCS on was really transsexual because she did so well *post-surgery*. Since decisions are actually made in this way means that doctors and therapists need to ground their work into an established body of medical and psychiatric knowledge, even if only superficially. Therefore, more than ever professionals seek out support from colleagues and official documentation, often fitting their decisions back into the SOC and DSM.

The most official forms of knowledge which exists for health workers around which they organize their work are the DSM-IV-TR and the SOC. While the DSM is used to diagnose patients and determine who is appropriate for treatments, the SOC are guidelines professionals use to assist patients through their transition from one gender to the other. Professionals use these documents in varying ways, many times re-working

them to ‘fit’ the decisions they have already made. Not one respondent completely rejected or totally adhered to them; most balanced usage in the struggle to be ‘good’ doctors rather than gatekeepers. Use of these forms along with types of acquired knowledge is a compelling example of how trans-medical knowledge is being currently developed, contested, and legitimized.

Professionals incorporate the DSM and SOC because doing so is functional to their work with patients and colleagues. Using the DSM and SOC provides legitimacy to doctors and therapists whose work and decisions are often seen as unconventional and unethical. They also use the DSM and SOC because in the absence of physical ‘proof’ of GID or because universally-agreed upon techniques for identifying or treating trans-people are rare, these documents are the next best thing. Having specific professionally-agreed upon guidelines provides a level of security for medical and mental health professionals. Adhering to official forms of knowledge provides providers with protection and legitimization. Following or at least fitting decisions back into these documents releases therapists and doctors from extreme responsibility and reduces the fear of being sued or losing their license. The paradox of using these documents is that using them too strictly means the professional is taking on a gatekeeper role. Using them too loosely is seen as unethical and dangerous. Therefore, medical and mental health workers must balance between these extremes to feel that the decisions they make reflect their vision of a ‘good’ doctor.

Both the DSM and the SOC, some argue, are needed so that medical and mental health workers can communicate and conduct research about trans-patients. The DSM,

especially the diagnosis of GID, is used to inform other professionals about whether someone is appropriate for transitioning services. Therapists indicate the diagnosis in the letter they provide to surgeons conducting GCS and other surgeries if the surgeon requires it. This letter tells surgeons that the patient they are about to perform surgery on has GID and hence is an appropriate candidate for such interventions and, but not always, tells them that the patient has had an on-going therapeutic relationship with that therapist. Although it is the surgeon who requires the letter from the therapist, often the doctor dictates either to the patient or the mental health professional what they want or need the letter to say in order to feel comfortable enough in providing transitioning treatments to patients. Therapists are therefore the ‘official’ deciders of who is appropriate, as their letter carries a lot of weight and protection for surgeons. However, it is the physician who many times orchestrates the formation of that letter. Surgeons override the letter and refuse to treat until they feel more confident with the patient’s appropriateness for surgical interventions, which usually requires that the therapist re-work and resubmit the letter.

The letter requirement is a paradox because as it provides legitimacy for surgeons to perform their work, it diminishes the work of therapists. Mental health providers want a relationship with patients to take time and follow a process, moving from one point to another. Being called upon simply to provide a letter, especially when its contents are directed by the surgeon, goes against the very nature of a therapist’s training. Their power is reduced, their skills wasted. The SOC requirement for a second letter for CGS only further deepens this paradox. A second letter is to more thoroughly ensure that

inappropriate surgical candidates do not make it to the operating table; however, a second letter only increases the pressure for therapists to conduct quick, gatekeeping functions, deciding if someone is appropriate, rather than putting therapeutic skills to use. These letters can be a false sense of security. While some do not question the letters but see them as a go ahead for surgical work, other surgeons indicated that they caught 'inappropriate' people when the therapist wrote them a letter indicating that the patient *was* appropriate for surgery. While all surgeons supported the use of letters, many indicated that they did their own screening process as well. Some surgeons commended themselves on being able to point out inappropriate candidates, despite approving letters from therapists. Letters are required because they relieve surgeons from a level of responsibility for doing such untraditional work. The small group of professionals who treat trans-patients feel that letters are important, and treating without collegial support would place more decision-making pressure upon one professional, increasing the opportunity for suits or losing one's license.

Providers also use official forms of knowledge because they feel it benefits the patient by saving them time and money. One professional explained it as 'putting the cart before the horse', meaning that if patients attempt to access transitioning services without following the process expected by the SOC, then they are merely wasting their time and money since they will have to eventually do it the appropriate way in order to gain approval to continue in their transitioning. For example, if a patient makes an appointment to see a surgeon and only has one letter indicating that she is good candidate for surgery, then the surgeon will most likely send that person to see another therapist

which will take perhaps another few months. Additionally, since that person will then have to set up another meeting with the surgeon once this expectation has been met, then they will likely have to pay again for the appointment.

Decision-Making Paradox

Due to the uncertainty of treating trans-patients, the lack of formal education and knowledge, and idiosyncratic uses of the DSM and SOC, doctors and therapists must alter the ways they care for trans-people. To accomplish this they re-define their role, re-establish what should transpire within the doctor-patient encounter, and even find new explanations to deal with problems that arise. Rather than making all the decisions, professionals re-interpret their role with trans-patients as educators, guides, and facilitators patients to help patients make their own decisions. This relieves professionals of pressure in being the sole decision-maker, especially because of a fear in losing one's license and because such medical work is rarely supported if something does go wrong. To rectify the problem, medical and mental health providers engage in professionally-guided patient decision-making, relinquishing some power to the patient and attributing the diagnosis and transitioning to the patient. However, they only allow patients to proceed in a way which the professional is most comfortable or as they feel it should unfold. When doctors and therapists come across a patient who does not respond or engage with them as they had hoped, they may refuse treatment.

Thus, negative unforeseen results are interpreted not as 'mis-diagnoses' or the fault of the professional but attributed to the patient or those in the patients' life. For example, in the case of a trans-person post-surgery who wanted to reverse GCS, a professional

explained that surgery had not been inappropriate but that the patient's religious beliefs or new partner had coerced them to change. Some even explain medical complications as stemming from patients' inability to follow doctors' directions or perform appropriate self-care. For a professional to admit a mistake could compromise and cast doubt upon the integrity of the SOC, DSM, professionals' skills, and the medical and psychiatric fields. Although no one in my study was confronted with the possibility of losing their license, nor knew any other professional who had, there was a looming fear that one could lose it at any moment.

Diagnosing

Most professionals, wanting to move away from the gatekeeper role, believe that patients should self-diagnose and choose their transition path. Professionals explain the ways in which they incorporate their understandings of both the DSM and the SOC in both diagnosing and treating trans-patients. Some find that a diagnosis is initiated by patients as a patients' story, which 'fits' into the definition of GID as stated in the DSM, will lead professionals to make an appropriate diagnosis. Since many professionals realize that trans-patients have read the DSM and SOC and know that they could create a story that is aligned with GID to ensure receiving such a diagnosis, mental health professionals still go through the process to appropriately diagnosis. Surgeons still expect patients to come with a letter of recommendation. Professionals usually expect a certain level of patient story-telling as they know that patients are knowledgeable and present themselves in ways to get the services they want. However, there is a point that patients' stories are interpreted as dishonesty which hinders the ability for doctors and

therapists to trust patients. Many find that part of the success of treating trans-people is developing a strong relationship with them; being dishonest is detrimental to the doctor-patient relationship and sets the professional up for failure as a 'good' doctor. In these situations, professionals may terminate the relationship.

How providers diagnose also depends on the purpose or goal and with whom the professional or patient is attempting to communicate with through the diagnosis.

Professionals still feel that it is their job to make an official diagnosis and rule out patients who are not really transsexual (i.e. transvestites or those who have co-morbidities) or who are not appropriate for life-changing transitioning procedures (i.e. surgeries, hormone therapy). If mental health professionals are writing a letter for a patient to obtain GCS, then they will diagnose the patient with GID. However, if a professional is filling out insurance forms, they will most likely officially diagnose the patient with something other than GID, such as anxiety or depression. Many times insurance companies refuse to cover mental health treatment since the current knowledge indicates that the only 'cure' for trans-people is a medical solution such as surgery, rather than a psychological one. Insurance companies will also refuse to cover medical claims related to transitioning, because GID is not a medical condition but a psychological one, especially since it is listed in the DSM. Many times, insurance companies have restrictions in their policies that exclude trans-individuals from receiving any type of assistance; only the most patient, dedicated, and savvy trans-person can find the loopholes. Worse yet, if insurance companies are aware that a patient has GID, they deny other medical claims arguing that transitioning causes other medical problems.

Professionals' diagnoses stem from their knowledge and understanding about trans-people while how they diagnose *on paper* is more likely to be guided by patients' needs and advice about how to present information to insurance companies. To address this paradox, therapists will often diagnose anxiety or depression so at least therapy can be covered. Some professionals acknowledge this or re-define their decision as the 'real' diagnosis to maintain the ethical view they have of themselves as professionals. One physician even admitted to using a false medical diagnosis not related to GID so that his patient could receive estrogen treatment without setting off red flags for the insurance company. Professionals often re-work the documents and diagnoses to best serve their patients. Many times they take advice from their patients about how and when to diagnose especially because patients are more aware of how the information may be used or misused. Patients know that records are not entirely confidential; release of information may open the doors to discrimination by employers and health care systems. Therefore, continual doctor-therapist communication is important to best meet the needs of the patient.

Treatment Path

One major issue about treatment is that regardless of the patient, medical and mental health professionals feel that there are particular options available, a particular time frame to adhere to, and specific other professionals who need to be on board in considering treatment. Professionals, despite patients' desires, must truly be the one to decide if a patient is ready to transition and how to transition. However, the fact that professionals take this role does not necessarily reflect a gatekeeper role but one of a

parent who cares and supports individuals. Many professionals feel that if they do not use their expertise and experience as guides then they are merely ‘setting up’ their patients. Patients are careful in how they speak about themselves, their experiences, and their interest in transitioning as they too realize that particular ‘red flags’ exist which could cause the professional to slow or cease their transition. When patients do not respond appropriately, professionals may refuse to treat.

Patients diagnosed with mental illnesses are disqualified from beginning their transition. While some patients do not have GID but rather another condition such as body dysmorphic disorder or transvestic fetishism, others have disorders such as depression and anxiety which create other problems during the transition. Although professionals believe that it is the patient who makes the decision to engage in the transitioning process, it is up to them to filter out those who do not have GID or to at least ensure that patients are well enough, mentally and physically, to make a sound decision. Taking on this role provides professionals with more confidence and less responsibility in making treatment decisions yet keeps them from losing patients or being seen as a gatekeeper by denying services to those who have mental illnesses. In such a small circle of professionals, many share information with each other about patients who are likely to cause the most problems. Some professionals see it as a challenge to help those with co-morbidity while others take heed and refuse to treat problem patients. How professionals and *if* professionals treat certain patients is based on their ability to organize their work in a way that will mostly likely lead to success. To be successful themselves, medical and mental health workers must retain their ability to be seen as knowledgeable, credible,

helpful, and worthy of respect. In order to achieve this, professionals must make treatment decisions which reduce the likelihood of future medical complications for their patients, improve the physical and mental state of their patients and at the same time adhere to enough of the established trans-medical knowledge to be seen as ethical by colleagues.

Larger Messages for Gender and Medical Work

Professionals' definition of difficult, successful, and rewarding patients reveals a lot about the knowledge, experience, and cultural views which organize their work. How therapists, doctors, and especially surgeons discuss successful patient and those who they feel would most benefit from surgery emerge from broad cultural perspectives about 'good' men, women and 'real' transsexuals. Their description of physically appealing and functioning bodies reflects an internalization of gendered norms and in turn, becomes embodied and incorporated into patients' psyche and behavior. Patients then present in already structured, logically organized ways, often aligning their experiences with the DSM and SOC, thereby confirming that medical knowledge is 'truth' and the sex and gender dichotomy is 'natural'.

Doctor-Patient Messages

Professionals expressed their concern with having to work with difficult patients, who made it challenging for professionals to not only do their work as they believed was most appropriate (i.e. aligned with current forms of medical knowledge) but to receive a desired perk to doctoring: patient gratitude and respect. Professionals defined difficult patients as those who had unrealistic social, surgical, and time expectations. Those with

unrealistic time demands created problems for professionals in allowing them to comfortably provide treatment according to the SOC. Additionally, when patients desire to rush their process, they in effect are not giving the professional enough time to do their 'job'. For example, for therapists, time is important in order to build a relationship with a patient, to get to know them so treatment and assistance can be administered. Time is also important for professionals because it provides them with the ability to feel comfortable and confident in diagnosing and treating. Some professionals' responses show that demands for quick services only engages professionals in a power struggle which makes them more likely to ensure that more time is spent. More time, perhaps, will reduce professionals' uneasiness about doing such work (not sure if patient is appropriate since they got a bad feeling from them) and will give more credence to the existing knowledge as professionals will be sure to follow outlined steps. However, professionals have to deal with time demands delicately as well since patients, if they feel professionals expectations are out of reach, will move on to another professional or, in the case of hormones, get them from the internet.

For professionals, trans-patients are also some of the most rewarding patients to work with. Professionals indicated that they found trans-patients to be, for the most part, well-informed, knowledgeable, compliant, and appreciative. Many trans-individuals, especially those who request GCS, have taken the time to learn a lot about gender dysphoria, surgeries, and the professionals who assist. Additionally, but not always, many patients undergoing GCS or other expensive surgeries, perhaps because they have the money to have such work, come from a background or class of individuals who are

most pleasant to work with for professionals. One doctor explained how many of her patients were highly successful individuals whom she found most rewarding because they were compliant, interesting, and appreciative of the work she was providing for them. Professionals discussed how their most rewarding experience with patients is when they could see the full transition: from a patient who has gender concerns but is not quite sure what to make of it to someone who, eventually, over time, makes the full transition. I would argue that this type of patient is most rewarding for professionals for three reasons:

- 1) When professionals can be a part of such a full transition, it makes them feel successful and that the patient has gratitude for what they have done;
- 2) Professionals who can be a part of the full process, because a process such as this will take time, feel comfortable that the time frame consistent with current SOC guidelines gives confidence that this patient is making the correct decision;
- 3) Lastly, at least for many patients, their goal is to move through a process, to come to some resolve whether it conclude with a deeper understanding of oneself or end with GCS, and the mere fact that it is a moving process is consistent with a successful therapeutic interaction according to many of the mental health professionals with whom I spoke.

Gendered Messages

Another important aspect of a successful patient is the larger implications for gendered messages and transgender knowledge more specifically. For many professionals, a successful surgery is one where the genitalia look and function appropriately, *sexually*, and to a lesser extent, whether they dispose of waste without complications. Additionally, a successful patient is one who is satisfied with surgical

results and their social life as the opposite gender, mostly measured by their ability to maintain *sexual* relationships. Specifying the success of a body and satisfying sexual relationship not only confirms the cultural importance and hence, ‘naturalness’ of sex, especially heterosexual sex, but also sustains the medical knowledge that the appropriate way to treat transsexuals is to get them to this point through the use of both medical and mental health professionals. The pressure is that this is the only way to be successful.

While many professionals feel that they want their patients to be successful with whatever decision they make, even if surgery is not for them, the pressure within the trans-community in which I conducted my previous research is very much focused on this progression rather than rewarding individuals for being in whatever point of the transition they wish to be. Hence, medical and therapeutic professionals, in their already held beliefs about the ‘naturalness’ of sex and gender support, if not encourage, patients to progress to the gender they believe themselves to be. When patients do not look or act as they feel is appropriate for our beliefs about ‘good’ men and ‘women’ then professionals attempt to move them in that direction or refuse to treat, thereby enforcing and policing strict gender boundaries. Therefore, similar to ‘normalization’ surgeries performed on intersexuals, trans-patients treatment by medical and mental health professionals can work to silence those who find themselves between genders which inadvertently lending credence that science reveals truths about bodies and gender is in fact naturally dichotomous.

Research Implications

DSM-V

One of the significant pieces of the debate is whether GID should remain in the upcoming DSM-V and whether the diagnosis of autogynephilia should be included. As professionals have shown, they need GID in the DSM, an official text, so they can clearly and unequivocally identify those individuals who are most appropriate for gender transitioning, especially something as irreversible as GCS. Having this as a medically recognized condition gives professionals the credence and support they need to assist trans-patients effectively and without, or at least with only minimal criticism by mainstream medicine. An official diagnosis provides a way for professionals to communicate about bodies so that appropriate treatment plans can be established. Official diagnoses also create a way for professionals to communicate with colleagues so that patients can receive the interventions they want. However, as professionals have discussed, this phenomena is a complex process where patient and professional discuss and decide on the use of an alternative diagnosis to GID in order to receive financial compensation and reduce possible future discrimination, especially since many insurance companies reject claims.

On the other hand, as some professionals relay, a diagnosis can pathologize what many feel should be considered a human variation. Trans-identified individuals' only option to medically transition by acquiring hormones or undergoing surgeries requires a GID diagnosis. Hence, trans-individuals have to relinquish their autonomy in order to access it. Being diagnosed with any disorder as listed in the DSM indicates a psychiatric

disorder. Having a psychiatric disorder can stigmatize individuals and open the door to increased discrimination and harassment. While many professionals state that a diagnosis is needed, many use a GID diagnosis only when writing surgical letters or communicating with colleagues. Mental health professionals do not diagnose patients with GID on forms meant for insurance companies as patients and experience have shown them that this only increases the likelihood of denied coverage. Mental health providers will diagnose a GID patient with depression or anxiety disorder so that insurance companies will cover at least their therapeutic sessions. Therefore, most professionals do want GID terminology to exist so that they can perform their jobs and assist patients but I would argue that it need not necessarily be in DSM as it can pathologize and stigmatize patients.

Another discussion underway is whether the DSM-V should include a new diagnosis: autogynephilia. The autogynephilic is a natal male who is sexually aroused by imagining himself as a woman. This term is hotly debated even within the WPATH listserv emails. On the one hand many trans-identified individuals find that such a term only further pathologizes trans-people, and even worse, many claim that it takes a group of people who normally would be seen as having a real gender issue and reduces their experience and identity to a mere paraphilia. I say it in this manner because what I found in my research a few years ago when I interviewed trans-people (Dewey 2008) was that there was an apparent hierarchy within the trans-community. ‘Real’ transsexuals did not want to be confused with cross-dressers or transvestites; cross-dressers are seen as sexually deviant while transsexuals dress because they believe themselves to be the

opposite gender and only they should be allowed to transition. Only a few professionals who I interviewed spoke about autogynephilia. They explained that while they felt it was useful for identifying and diagnosing their patients, believed that others' rejection of the term were simply misunderstanding it. This is a major concern for both trans-identified people and the professionals who assist them.

I believe that this is a difficult discussion because I have seen support for the separation of the diagnosis of GID and Transvestic Fetishism by both professionals and trans-patients alike as well as the possible inclusion of autogynephila by some professionals. Having these terms provides a way for trans-identified individuals to establish their identity. Having a paper trail and an official diagnosis by an 'expert' establishes a viable identity for patients. And many times, especially since society is less accepting of those whom they believe to be sexually deviant, even transsexuals want to be recognized as not being simply cross-dressers. However, I would argue that separating GID from TF and including autogynephila, which in essence is seen as a subset of previously diagnosed GID individuals, creates a situation for all trans-people that forces them to deny any sexual aspect of their identity, since professionals may demonize them for being sexually aroused. Therefore, trans-individuals may feel pressure to present a false identity to gain services they need to realize their 'true' identity, or worse yet, forgo what they believe is their 'true' identity in order to be accepted by others.

SOC (7th Edition)

Key members of the World Professional Association of Transgender Health (WPATH) are currently discussing the 7th revision of the Standards of Care. Currently, the SOC document is undergoing changes to its, soon to be, 7th edition (SOC). Some of the recent changes proposed by members of WPATH include altering its language. Some suggest that guidelines should reflect both various cultures, not just those transitioning in Western countries, and alternative transitional choices desired by patients (i.e. to not assume that everyone desires the particular path set out by the SOC). Some desire a more internationally accepted document to ensure that all practitioners are following the same standards thus increasing the opportunity for professionals to be licensed or credentialed as a 'gender specialist'. Additionally, some WPATH members request that gender specialists should use the DSM only if they choose, but that they should not have to officially diagnose anyone according to the DSM in order to assess or treat patients (SOC).

My work has implications for the discussions presently underway. Both the SOC and how most professionals understand their work diminishes the possibilities for trans-individuals, limiting a proper transition as only one aligned with the Western culture and its gender/sexual dichotomy. I found that most professionals, even if verbally indicating that they allow patients to guide them, have a clear idea of a particular process and a specific content of that process that should transpire. The goal for professionals is to assist patients in realizing 'who they are' with progress usually measured by transitioning from one gender to the other through therapy, surgery, presentation in everyday life, and

success in their social life. Moreover, a patient must be willing to engage in this progression, a process reflected in the DSM, SOC, and what professionals have told me about how they do their work which consists of a diagnosis, a treatment plan, a letter, and eventually surgery. While many professionals indicated they were fine with whatever patients decided, they had a clear underlying expectation of what exactly should unfold to consider their patient to be 'successful'.

I believe my work sheds light on how changes in the SOC might encourage professionals to think of their time with patients differently; however, I would contest that more needs to be done to change the mindset of what it means to 'doctor'. Even while the SOC indicates that its contents are meant to be used fluidly or as discussed and agreed upon by doctor and patient, it is also quite specific and repeatedly reminds the reader that therapists, surgeons, and patients are equally responsible for all decisions, since this work can be irreversible. WPATH's interest in creating a more internationally standardized document can both solve and create problems. I think that it may be difficult to develop more clarity and standardization while at the same time creating more fluidity and options for trans-people cross-culturally. I believe it would be challenging to make a document more clear and concise in order to train others and taken seriously by mainstream medicine while at the same time allowing medical and mental health professionals more leeway in how they treat.

Professionals also feel that there should be more opportunities for formal education. While many had to acquire the bulk of their knowledge through non-formal knowledge acquisition, they agreed that they wished there had been more available

programs or coursework pertaining specifically to trans-individuals. I would argue that having programs and opportunities for specific credentialing would provide professionals with more exposure to the issues faced by trans-people as well as the knowledge they need to best treat their patients. Progress would also provide chances for increased interactions with other professionals who treat trans-patients, allowing for future networking. On the other hand, if the only way to achieve this is to internationally standardize the SOC and ensure that all professionals assisting trans-individuals are certified exactly the same then this could continue to perpetuate trans-medical knowledge which, I would argue, reflects that the only successful patient is one who progresses with particular ‘experts’.

Finally, my work has implications for the last part of WPATH members’ discussion for the 7th revision of the SOC. One request is that gender specialists’ should use the DSM only if they choose, but that a professional should not have to officially diagnose anyone according to the DSM in order to assess or treat patients. Professionals in my study show that they do not officially diagnose patients as having GID as doing so sends ‘red flags’ to patients’ insurance companies. An official diagnosis of GID can open up the door to discrimination and harassment by including denial of insurance coverage and if the information were to leak out to their employer and possible termination from a job. Changing this in the SOC would mean only that professionals did not have to ‘rework’ the guidelines to better assist their patients. However, removing the requirement that professionals would have to diagnose someone as having GID in

order to access further transitioning services such as hormones or GCS, creates an interesting dilemma.

When I questioned many professionals about how they would feel about removing GID completely from the DSM so that treating trans-people would reflect more of a consumer desiring a service, most were quite uncomfortable with that. Some felt that removing GID completely from the DSM would mean that professionals no longer had the ability to talk about or research what they believed to be a real issue or condition. ‘How can we assist people if we cannot talk about it? How can we treat something if we do not agree that it exists?’ Many therapists, especially, stated that while they did not believe patients should be stigmatized or pathologized, did feel that GID needed to be somewhere in order to speak about and offer relief to patients as they found that patients experiences and distresses concerning gender were real. If an official diagnosis of GID was no longer needed then would this mean that surgeons would no longer require two letters to perform gender confirmation surgery? If this were the case then there would really be no need for patients to seek out a therapist unless they desired the relationship to assist in the process.

Mental health providers, on the other hand, may find that their time with patients who chose to seek out their services, rather than being required to would find their jobs more rewarding. Additionally, dropping the letter expectation would also mean that therapists and surgeons would not be required to communicate with each other about the appropriateness of a patient for surgeries. Therefore, the attempt of WPATH members to establish a ‘gender team’ would not be needed. Finally, removing the requirement of a

letter to perform surgery would perhaps change the way surgeons evaluate and screen gender confirmation surgical patients, eliminating pressure to ensure that patients are ‘appropriate’ at all. If patients were viewed as consumers wanting a service, those with the most money and ability would receive services. This could be viewed as having more, and less, control over one’s work. Perhaps with this, professionals would will feel less pressure in making decisions and therefore not have to balance between the good doctor and gatekeeper roles. On the other hand, health care workers will no longer have to apply particular steps as outlined by the SOC which can lessen the need for professionals to make decisions which some may enjoy as a part of doctoring. The upcoming versions of the DSM and SOC will certainly create changes in the ways professionals treat trans-people.

We should take a more critical look at the perception that knowledge is objective and static. This project reveals that how knowledge is created, applied, and legitimized stems from a process, including many individuals. Our views about what makes an appropriate doctor, therapist, patient, and trans-person are consistently negotiated within the doctor-patient relationship. While these interactions are always in flux, they have real consequences for trans-people, both inside and outside the medical and psychiatric arenas. What does not get challenged are the contradictions and paradoxes found in the understanding and use of the current knowledge. Additionally, what also does not get deconstructed is how we have come to define ‘success’ for trans-bodies and professionals’ refusal to treat those whom they feel will not be successful post transition. I believe that my study explores the complexities of trans-medical knowledge and how

its' unfolding between many actors is continually being created, contested, and legitimized. It speaks to both the ways we organize medical and therapeutic work and the ways we decide who is worthy of medical and psychiatric interventions. Most of all, it sheds light on the fact that knowledge is malleable.

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